

**WOMEN EMPOWERMENT IN RAJASTHAN
WITH SPECIAL REFERENCE TO HEALTH AND
EDUCATION: A SELECT STUDY OF KOTA AND
JAIPUR DISTRICTS**



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I, **Vasudha Pandey**, hereby certify that the research work presented in my Ph.D. thesis entitled “**Women Empowerment in Rajasthan with Special Reference to Health and Education: A Select Study of Kota and Jaipur Districts**” which is carried out by me under the supervision of **Dr. Anil Kumar Pareek, Professor, Department of Public Administration, Government Arts College** and submitted in the partial fulfillment of the requirement for the award of the degree of Doctor of Philosophy of the University of Kota, represents my ideas in my own words and where others’ ideas or words have been included in this thesis, I have adequately cited and referenced the original sources.

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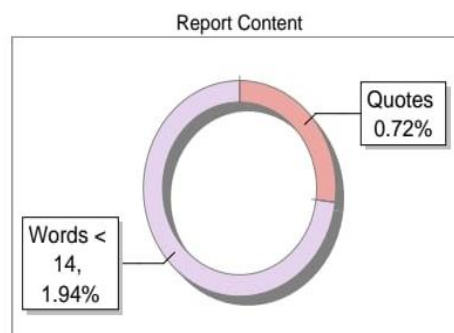
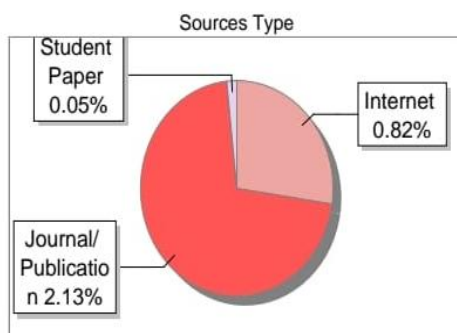
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ABSTRACT

Women's empowerment refers to the process of enabling women to exercise control over their lives and the situations they are in. It extends beyond economic independence or political participation to include physical health, mental well-being, educational access, a sense of security, and social agency. Mental health is a crucial yet often neglected dimension of women's empowerment, functioning both as a foundation and an outcome of development. The interaction between mental health and empowerment becomes particularly complex across different life stages, as women encounter distinct psychological and social challenges during adolescence, motherhood, and in accessing education, especially when they are differently abled. Rajasthan, owing to its geographical size, socio-cultural diversity, and demographic complexity, provides an important context for examining women's empowerment through this comprehensive lens. The districts of Jaipur and Kota were selected to capture variations across urban and semi-urban settings, enabling a comparative understanding of empowerment outcomes within the state.

The primary objective of this study is to examine the status of women's empowerment in Rajasthan with special reference to health and education through a comparative analysis of Jaipur and Kota districts. The study specifically focuses on the mental health of female adolescents aged 15–19 years residing in these districts and analyzes differences across three criteria: district wise variation (Jaipur and Kota), age groups (15–17 years and 17–19 years), and living arrangements (staying at home and away from home). It further examines help-seeking behaviour among female adolescents. Additionally, the study explores postpartum mental health through the perspectives of healthcare providers and investigates the declining enrolment of differently abled females in higher education in Rajasthan from 2017 to 2022, based on AISHE reports. The research seeks to assess the prevalence of mental health challenges, identify socio-administrative factors influencing access to services, evaluate policy effectiveness, and highlight district-level variations in implementation.

The study adopts a mixed-methods research design. Primary data for the adolescent mental health component were collected over a one-year period through structured questionnaires, field surveys, and interviews with female adolescents in Jaipur and Kota districts. Postpartum mental health data were collected from healthcare providers using structured questionnaires. For the education of differently abled women, both primary data from educators and secondary data from government reports were used. Quantitative data were analysed using statistical techniques, primarily chi-square tests and t-tests, while qualitative data were analysed thematically to understand institutional practices, policy gaps, and lived experiences.

The findings reveal significant gaps between policy frameworks and ground-level implementation. Contrary to popular belief, while adolescent girls in both districts experience high levels of academic stress, stress levels were found to be higher in Jaipur than in Kota. Students staying with their parents reported greater academic stress compared to those staying away from home, and older adolescents experienced higher stress levels than younger adolescents. According to healthcare providers in Jaipur and Kota districts, approximately 10 per cent of women out of 1,000 were reported to be suffering from postpartum mental health issues, with limited screening, persistent stigma, and inadequate institutional mechanisms. The study also identifies economic, physical, societal, and cultural barriers in the education of differently abled women, along with low awareness of inclusive education policies. Comparative analysis highlights variations in access to services and institutional support between Jaipur and Kota, challenging generalized assumptions regarding regional mental health outcomes.

The study concludes that women's empowerment in Rajasthan remains constrained by fragmented policy implementation and insufficient integration of health and education sectors. Addressing mental health and inclusive education as core components of public policy is essential for sustainable empowerment. The findings underscore the need for gender-sensitive, district-specific interventions, improved administrative coordination, and strengthened institutional accountability to promote equitable health and educational outcomes for women in Rajasthan. empowerment cannot be meaningfully achieved when mental health is overlooked, as

psychological well-being forms a foundational component of women's ability to exercise agency, participate in education, and access opportunities. Likewise, inclusive development cannot be realised unless all key sections of society are adequately represented, particularly differently abled women who continue to face systemic exclusion within educational and institutional frameworks.

Key Words: Women Empowerment, Rajasthan, Jaipur, Kota, Adolescent, Postpartum, Divyang Female

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ABBREVIATIONS

Abbreviation	Full Form
AB-PMJAY	: Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana
ADHD	: Attention Deficit Hyperactivity Disorder
AISHE	: All India Survey on Higher Education
ANM	: Auxiliary Nurse Midwife
ASHA	: Accredited Social Health Activist
CAMH	: Child and Adolescent Mental Health
CBME	: Competency-Based Medical Education
CBT	: Cognitive Behavioral Therapy
CHC	: Community Health Centre
DALYs	: Disability-Adjusted Life Years
DEPWD	: Department of Empowerment of Persons with Disabilities
DIB	: Development Impact Bond
DMHP	: District Mental Health Programme
ECCE	: Early Childhood Education and Care
IDEA	: Individuals with Disabilities Education Act
IEC	: Information, Education and Communication
INAP	: India's Newborn Action Plan
ISL	: Indian Sign Language
LMIC	: Low- and Middle-Income Countries
MHCA	: Mental Healthcare Act
MMAP	: Measurement of Mental Health Among Adolescents at the Population Level
MOOC	: Massive Open Online Courses
NCLB	: No Child Left Behind Act
NCRB	: National Crime Records Bureau
NCTE	: National Council for Teacher Education
NEP	: National Education Policy

Abbreviation	Full Form
NHM	: National Health Mission
NHRC	: National Human Rights Commission
NIMHANS	: National Institute of Mental Health and Neurosciences
NMHP	: National Mental Health Programme
NMR	: Neonatal Mortality Rate
PHC	: Primary Health Centre
PMSMA	: Pradhan Mantri Surakshit Matritva Abhiyan
PND	: Perinatal Depression
PPD	: Postpartum Depression
PFGD	: Perceived Familial Gender Discrimination
RMNCH+A	: Reproductive, Maternal, Newborn, Child, and Adolescent Health
RCI	: Rehabilitation Council of India
RPWD	: Rights of Persons with Disabilities Act
RSMHA	: Rajasthan State Mental Health Authority
SD	: Standard Deviation
SEN	: Special Educational Needs
SMD	: Severe Mental Disorders
SSA	: Sarva Shiksha Abhiyan
SWAYAM	: Study Webs of Active-Learning for Young Aspiring Minds
UDL	: Universal Design for Learning
UMMEED	: Understand, Motivate, Empathize, Empower, Develop
UNCRPD	: United Nations Convention on the Rights of Persons with Disabilities
UNICEF	: United Nations Children's Fund
WHO	: World Health Organization

Chapter 1

Introduction

CHAPTER 1

INTRODUCTION

This chapter is divided into **four sections**.

The **first section** discusses the **Overview (Significance of the topic selected for Thesis)** of the chapter.

The **Second section** discusses the following:

- **Review of Literature**
 - Adolescent Mental Health
 - Postpartum Mental Health
 - Education for Divyang Female
- **Inferences drawn from the Review of Literature**
- **Research gap**

The **Third section** discusses the following:

- Objectives of the research
- Hypotheses of the research
- Research Methodology
- Scope of Research

The **Fourth section** provides a brief on **Chapter Scheme**.

I

Overview

Empowerment, according to the Oxford Dictionary can be defined as ‘the act of giving somebody more control over their own life or the situation they are in’. It extends beyond mere economic independence or political engagement; it must include the intricate relationship among physical health, emotional well-being, educational achievement, feeling of security and social agency. Nina Wallerstein defines Empowerment as ‘the interaction of reflection and action, or praxis, that can transform social conditions. It is this critical thinking based on action, or conscientization that links personal and community empowerment’(Wallerstein, 1992).

‘Women’s Empowerment’ became popular in the 1980s and 1990s as a radical approach concerned with transforming power relations in favor of women’s rights for them to achieve greater equality (Cornwall, 2016). Rogers re-defined Empowerment as ‘one who has self-efficacy and power. The empowered person recognizes use of anger as a motivating force to instigate social change and is optimistic about the ability to exert control over his or her life.’ (Rogers et al., 1997)

Mental health is a crucial yet frequently neglected component of women's empowerment, functioning as both a basis and a result of significant development. The complex interplay between mental health and empowerment becomes more nuanced when analyzed throughout several life stages, as women encounter unique psychological and emotional challenges at different ages. Adolescent mental health is a critical phase in which essential psychological patterns are formed, and unaddressed mental health concerns during this time can extend into adulthood, jeopardizing scholastic and economic chances. Poor mental health is a curse to an otherwise healthy age. Adolescence is a time of transition and confusion and mental health crisis only makes it worse.

Postpartum mental health, which includes postpartum depression and anxiety disorders, represents a significant vulnerability where women's psychological resilience is challenged after a major biological and social transition, yet it continues to be heavily stigmatized and inadequately addressed in numerous Indian contexts. Genuine empowerment necessitates a sectoral integration that unites health systems, marriage institution, social welfare mechanisms, and governance structures to collaboratively tackle the complex challenges encountered by women, especially in their varied circumstances. No sector can attain sustainable empowerment outcomes independently; health advancements without educational access is a sloppy, educational progress without mental health support is meaningless, policies without proper implementation is futile and implementation without thorough evaluation is moot.

Education is yet another component of Empowerment especially for women who have been denied of this basic right for centuries due to various reasons and

circumstances. It becomes even more crucial if the woman is differently abled. Her empowerment in true sense will only emerge if she is well educated and aware of her rights and opportunities available for her. It is only possible through education- not just textbook but also skills.

Rajasthan, being India's largest state in terms of geography and demographic complexity, serves as a significant and illustrative case study for analyzing women's empowerment through this comprehensive perspective. The state has long contended with some of India's most enduring gender disparities, including elevated maternal death rates, poor female literacy rates, and deeply rooted patriarchal social systems. Rajasthan exhibits significant variety within its districts, characterized by disparities in socioeconomic growth, urbanisation trends, and social variables, rendering district-level study essential for comprehending context-specific empowerment difficulties.

The districts of Jaipur and Kota hold unique yet interrelated places within this environment. Jaipur, the state capital and its most urbanized region, exemplifies rapid growth juxtaposed with enduring traditional gender norms- a dichotomy that renders it essential for examining the intersection of urbanisation and modernity with women's empowerment outcomes. The district's superior infrastructure, healthcare services, and educational establishments conceal profound structural disparities and burgeoning mental health issues linked to urban stress, aspirational discrepancies, and evolving family dynamics.

Kota, on the other hand, embodies a semi-urban to rural environment distinguished by varying developmental paths, population structures, and social dynamics. Kota, historically recognised for its agrarian economy and subsequent development as an educational center, exhibits unique trends in women's workforce engagement, educational accessibility, and health vulnerabilities. The intentional choice of these two opposing yet interrelated districts facilitate a more nuanced comprehension of the varying manifestations of women's empowerment throughout urbanisation spectrums, while accounting for state-level policies and cultural settings. The comparative comparison of Jaipur and Kota serves as a microcosm for examining and understanding broader trends of women's empowerment and disempowerment throughout Rajasthan.

Although contemporary research on women's empowerment has provided significant insights through psychological and academic frameworks, these approaches, while informative, are inadequate for translating conceptual understanding into concrete, systemic change in practice. The essential gap exists in this area: awareness of the psychological obstacles women encounters or comprehension of educational inequities does not inherently resolve how these issues should be addressed via institutional frameworks, resource distribution, policy alignment, and program execution across various regions and social demographics.

At this point, Public Administration arises not as an ancillary viewpoint but as a crucial and necessary analytical framework. Public Administration, being a field rooted in governance, institutional architecture, and policy execution, has the distinct ability to connect the identification of issues with its resolution. While psychology and education help in analysing and formulating the theories, Public Administration constructs the institutional framework that implements solutions. This study fundamentally aims to understand the mental health issues faced by women in two very different stages of her life that is adolescence and postpartum and the education of differently abled women to investigate the governance structures, policy mechanisms, institutional capacities, and implementation frameworks that either facilitate or hinder women's empowerment in practice. Public Administration emphasizes on inter-sectoral coordination, institutional accountability, resource management, and grassroots implementation. It enables it to enquire not only what hinders women's empowerment but how governance systems that align with policies and coordinate with institutions and its implementation mechanisms are formed. Furthermore, Public Administration ensures what is guaranteed in the Constitution of India, introduces a crucial focus on equity and justice. It does a systematic inclusion or exclusion of vulnerable populations - such as women with disabilities, adolescent girls, and postpartum women - from policy frameworks and service delivery systems.

The conceptualization of women's empowerment through an integrated, multi-sectoral, lifelong, and intersectional framework within the context of Public Administration is thus both contemporary and essential. Public Administration offers

theoretical and methodological frameworks to analyze how government policies and programs - across health, education, social welfare, or justice - either promote or obstruct women's empowerment, and how institutional capacity, resource distribution, inter-departmental collaboration, implementation strategies, and accountability systems influence real-world outcomes. When analysing mental health services for women of varying ages from a Public Administration perspective, the present study not simply record individual psychological conditions but critically evaluate the sufficiency, fairness, coordination, and efficacy of public health systems and their institutional ability to cater to all women. This study is relevant to Public Administration because empowerment depends on policy implementation, institutional coordination, and governance capacity, not just awareness.

Investigating educational access and security for differently abled women involves examining educational theory, institutional adherence to inclusive education mandates, resource distribution for special needs infrastructure, and the practical realities of implementation. In this research of women's empowerment in Jaipur and Kota, it systematically assesses the impact of governance frameworks, policy execution, inter-institutional collaboration, and accountability systems on the lived experiences of women across the empowerment continuum.

Good public policy in health is really tested in implementation; it goes much beyond formulating ambitious goals. As O'Flynn (2016) underlines, many health policies underplay the complexity of public administration systems that have to be carried out rather than result from poor design. Policy delivery is frequently hampered by the 'hard grind' of negotiating bureaucratic procedures, disjointed government systems, and conflicting departmental priorities. Multiple social factors - education, sanitation, housing - necessary for what O'Flynn describes as a 'joined-up government' shape health outcomes, especially in areas like adolescent or mother mental health. Still, limits between institutions - functional, cultural, or jurisdictional - cause coordination to be hampered. These limits are often reinterpreted instead of being eliminated by reforms; hence, new competencies and intersectoral strategies are needed to be properly controlled. Therefore, public policy in health has to be created with great awareness of these administrative dynamics by means of

multidisciplinary cooperation between public health experts and public administration scholars, so closing the ongoing discrepancy between policy intentions and actual outcomes (O’Flynn, 2016).

Even though adolescent mental health is increasingly becoming a policy focus, evidence-based policymaking is still dispersed throughout India. The effectiveness of public health policy formation is limited by mental health policy procedures, which frequently rely on politically motivated arguments or internationally recognized evidence rather than compelling local facts. Formal, quantitative data are frequently preferred by policymakers over evidence gathered from the community. This tendency reduces the relevance of interventions in many local contexts and restricts the inclusivity of public policy in the health sector. Implementation mechanisms are necessary for health policies to be effective. Adolescent mental health policy in India is still hindered by stigma and low political priority. Mental health risks are frequently overlooked on health agendas unless there is a deliberate shift in the way public policy is framed. Public health strategies that ignore the lived experiences of teenagers run the risk of creating ineffective, top-down solutions. Making health policy more evidence-based and responsive requires prioritizing participatory policymaking, especially with regard to youth (Ivory et al., 2024).

India's strategy to address the mental health requirements of 253 million individuals aged 15 to 24 is informed by the Mental Healthcare Act 2017 (MHCA) (THE MENTAL HEALTHCARE ACT, 2017), which promotes a rights-based framework for accessing mental health services, the National Mental Health Policy 2014, and the National Mental Health Program, which has been in operation since 1982. We conducted an extensive narrative review of policies, programs, and legislation from five ministries of the Government of India - Health and Family Welfare, Education, Women and Child Development, Youth Affairs and Sports, and Social Justice and Empowerment - over the past decade to delineate their strategies and identify facilitators and obstacles in advancing youth mental health in India.

All five ministries acknowledged mental health as a crucial component of the entire growth and well-being of youth. Nonetheless, their methodology is disjointed, and a

holistic strategy for youth mental health is absent in the Indian setting (Murthy, 2017). Given that three-fourths of all lifetime mental health issues manifest by the mid-twenties, it is imperative for nations to establish a robust and comprehensive strategy to address the mental health of their youth. Existing policies and programs for adolescents and young individuals prioritize mental health for comprehensive youth development and well-being, acknowledging the necessity to enhance access to mental health information, resources, and services. However, the approach across sectors remains disjointed and insufficient. Significant obstacles, including inadequate awareness of mental health issues, negative attitudes towards seeking assistance, and the societal stigma around mental health, are insufficiently prioritized (Girase et al., 2022).

II

Review of Literature

The following section discusses Review of Literature for three different chapters separately.

Firstly, it deals with ‘Adolescent Mental health’ including references from Government Policies/ Programs/ Schemes followed by research papers and Books.

Thereafter, this section presents elaborate review of literature on ‘Postpartum mental health’ including literature from Government Policies/ Programs /Schemes followed by relevant research papers and books.

Lastly, it deals with ‘Education of Divyang Women’ with literature from Government Policies/ Programs/ Schemes followed by research papers and Books.

After a thorough review of literature, this section focuses on the inferences drawn from each section and identifies research gaps in each of these literatures, immediately after each of its review of literature.

1.1. Adolescent Mental Health

a) Government Policies/Programs/Schemes

- **Mental Health of adolescents, World Health Organization** Adolescence (10-19 years of age) is recognized as a formative and sensitive period, where exposure to adversity such as, abuse, and violence which heightens vulnerability to mental health problems. The estimated prevalence of mental health conditions is 14.3% in adolescents all over the globe yet most cases remain unrecognized and untreated, significantly due to stigma, social exclusion, discrimination, and limited access to care. Mental health disorders include Depression, anxiety, ADHD, eating disorders (affecting girls disproportionately), and behavioral disorders which has emerged as the leading causes of illness and disability, with suicide ranking as the third leading cause of death among those aged 15–29. Evidently, the issues that start in adolescence affect the adulthood, if unaddressed and not treated in time. Finally, the literature underscores the urgent need for early intervention and comprehensive, multi-sector efforts to promote adolescent mental well-being and prevent suicide.
- **UNICEF** mental health initiatives such as Measurement of Mental Health Among Adolescents at Population level (MMAP) aim to improve data collection and understanding of adolescent mental health needs to inform targeted programs. A comprehensive approach involving psychological, social, and community support is essential to foster resilience and healthy development, ultimately ensuring a smoother transition to adulthood.
- **(World Health Organization, 2025)** emphasises that adolescent anxiety and depression impair school attendance, academic functioning, and social behaviour, and highlights suicide prevention as a global public health priority. WHO also urges national mental health strategies, school-based interventions, and community support frameworks.
- **National Mental Health Survey of India, 2016** includes specific findings for Rajasthan, revealing the state's lifetime mental morbidity prevalence as 15.4% and current mental morbidity at 11.6%. The survey also notes substantial variation in the prevalence of specific disorders across different

Indian states, with Rajasthan showing particularly high rates for certain neurotic and stress-related disorders. The adolescent mental morbidity prevalence in Rajasthan aligns with national trends, sitting near the overall figure of 7.3% for this demographic, and is notably higher in urban metro areas. The treatment gap for mental health disorders in Rajasthan, as in many other states, remains significant - ranging from 70% to over 90% for different disorders.

- **(Ministry of Education, 2022)**'s 'Modular Handbook for Teachers and Allied Stakeholders' provide a comprehensive whole-school approach to mental health and well-being for school-age children and adolescents. It focusses on early detection and intervention for mental health issues, providing teachers and carers with the required skills for psychosocial first aid and support. The initiative marks the importance of creating safe, inclusive, and emotionally supportive learning environments, as well as good teacher-student connections, in order to increase student attendance, engagement, and resilience. Key components include sensitisation sessions for school staff and parents, referral systems for abuse or mental health concerns, and stress-related behaviour detection training. Independent Complaint Committees should be there to address and treat mental health issues. Overall, the findings are consistent with the NEP 2020 and Safe Schools standards for creating environments that prioritise emotional well-being and holistic development in schools for children and adolescents.

b) Research Papers

- **(Shergill & Rathore Hooja, 2025)** examines the influence of perceived familial gender discrimination (PFGD) and entrapment on the mental health of emerging female adults in India. The sample consisted of 568 unmarried and unemployed female college students, aged 18 years and older, from upper- and lower-middle-class socioeconomic backgrounds, selected using purposive sampling. The findings demonstrate a substantial positive correlation between PFGD and entrapment ($r = 0.653$, $p < 0.01$), indicating that elevated perceptions of discrimination correlate with heightened

experiences of entrapment. This data underscores the significant influence of familial gender discrimination on the psychological well-being of young women, resulting in an elevated sense of entrapment. The study highlights the significance of tackling gender discrimination in families to enhance the mental health outcomes of emerging female adults.

- **(S. Pal et al., 2025)** investigates the rising incidence of mental health issues and suicides among adolescents in India, focusing on coaching hubs such as Kota, with the goal of analysing mental health conditions and suicide rates among adolescent coaching aspirants, identifying contributing factors, assessing existing support systems, and proposing interventions to address the crisis. The paper finds that the suicide rate among Kota students is much higher than the national average, and it links parental anticipation, extreme academic pressure, social isolation, and a lack of mental health care as primary drivers to suicidal thinking. Despite government investments, gaps in mental health services persist, showing that current approaches are insufficient to address the multifaceted stresses encountered by students.
- **(Sharma & Sharma, 2025)** examines the disparity in psychotherapy access for adolescent mental health in India within a tertiary care context. The study took a mixed-methods approach to investigate individual and socio-contextual determinants affecting help-seeking behaviours. Quantitative analyzes of data from 74 adolescents, predominantly urban females from nuclear families diagnosed with neurotic disorders and largely inexperienced with psychotherapy, indicated negative correlations between attitudes towards seeking psychological treatment and both self-stigma and perceived obstacles to assistance. There was a favourable between working class and treatment-seeking attitudes.
- **(V. Gupta et al., 2025)** reports high levels of depression, anxiety, and stress among young adults in Jaipur (aged between 18-30), highlighting an urgent need for comprehensive intervention. Anxiety was found to be 58.11% followed by depression (48.57%) and stress (25.39%).
- **(Balamurugan et al., 2024)** assess mental health issues among Indian adolescents by doing systematic reviewing 31 studies of Indian adolescents.

Depression was the most prevalent issue followed by social, behavioural issues, anxiety, social phobia, and other issues. The review suggested that the healthcare professionals should collaborate with the parents and the teachers to curb the issue.

- **(Dandona et al., 2023)** analyzes the sociodemographic characteristics of the Indian women who died by suicide in India from 2014 to 2020 from the surveillance data from the National Crime Records Bureau (NCRB). Predominance of suicide deaths among educated women, among those who are currently married and those who have never married at the population level, as well as variations in the reasons for and methods of suicide at the state level was found. The study urges for specific and multisectoral interventions to address these deaths.
- **(Prabhu et al., 2023)** studies the magico-religious beliefs, stigma and help-seeking for adolescent mental health at the community level in Southern part of India. It found a correlation between cultural beliefs and the help-seeking behaviour. An important step to deal with mental health issues is targeting the community on sensitizing and destigmatizing issues surrounding mental health issues.
- **(Zhou et al., 2020)** examined the current state of child and adolescent mental health (CAMH) policy in low- and middle-income countries (LMICs), identifying significant gaps and challenges in policy development and implementation. They emphasised that LMICs generally lack dedicated CAMH policies, which impedes adequate mental health care for youth. The authors identified a number of challenges, including stigma, limited public knowledge, inadequate data, resource limits, and fragmented international support, that make long-term policy efforts challenging. Their systematic assessment of 31 articles, including research from India, found fragmented policies, insufficient provider training, and a lack of stakeholder involvement. The findings emphasised the critical need for stand-alone CAMH policies, effective resource allocation, inclusive stakeholder involvement, and collaboration with the social and educational sectors to improve outcomes.

- **(Maheshwari et al., 2020)** studies how family structures affect mental health issues of female adolescents in India. The cross-sectional study focused on a small village of Punjab where 900 female (aged 11-19) were conveniently selected. Mental health issues can be dealt if professionals and community health nurses take the early initiative to identify any malfunction in families.
- **(Deb et al., 2016)** examined depression in Indian university students and its relationship to academic environment, residential situations, and personal difficulties. Depression is a pervasive and severe disease that affects academic and psychosocial functioning, yet Indian universities lack mental health support services like counselling. About 53% of 717 Pondicherry University students had moderate to severe depression, with higher rates among early-semester students, humanities/social science majors, poorer academic performers, and those with negative family or university environments. The findings showed that Indian colleges need mental health care, targeted counselling, and awareness campaigns immediately.
- **(Aggarwal & Berk, 2015)** analyzes 27 research conducted over the previous ten years. The research found out suggest an increase in psychiatric illness, depression, anxiety, and suicidal behaviour among Indian teenagers, but wide variances and methodological constraints prevent decisive findings. Female gender, academic challenges, family conflicts, and unique context-specific characteristics such as the mother's job status and nuclear families are all risk factors. According to the researchers, the socioeconomic developments in India provide an ideal backdrop for investigating mental health issues.
- **(Ram et al., 2014)** explores gender socialisation among Indian adolescents using data from over 44,000 people from six states. The study covers six states: Bihar, Jharkhand, Maharashtra, Rajasthan, Andhra Pradesh, and Tamil Nadu. It discovers that young female experiences more limits on independence and less rights than male youth, despite having more gender-equal attitudes. The study focusses on still prevalent gender inequality in Indian households and its major impact on youth mental health.

- **(Windfuhr & Kapur, 2011)** summarises 15 years of findings from the UK's National Confidential Inquiry into Suicide, emphasising the relationship between mental illness and suicide risk. Approximately 90% of suicides include people with mental illnesses, who are at a 5 to 15 times higher risk than the general population. The Inquiry identified important high-risk times, such as the first week after discharge from psychiatric inpatient care, and emphasised the need for communication and safety measures in mental health services. But the risk assessment remains complicated.
 - **(Shatkin & Belfer, 2004)** analyzes that the global landscape of child and adolescent mental. Very few countries have dedicated mental health policies for youth, just 14 of the 191 nations assessed had legislation explicitly recognising child and adolescent mental health, indicating a global insufficiency. Evidence from India demonstrates this worldwide trend, where mental health policies operate primarily within broader national health frameworks, with no unifying child and adolescent focus, despite the high prevalence of psychiatric disorders among school-aged children.
- c) **Books**
- **(Kanfode, 2024)** highlights the struggle, stigma and shame women feel in their entire lifetime and suffer silently due to mental health issues. Various aspects of mental health crisis of women from adolescence to adulthood; reproductive years to menopause; physical and sexual violence; impact of parent's relationship on child's mind is discussed in detail. Author discusses the genetics, nutritional status, socio-economic factors, BMI, and other factors that causes early menarche (beginning of menstrual cycle in female) in detail. He further discusses the risk-taking behaviour in adolescent girls related to substance abuse, self-harm, risky sexual behavior and resources to seek help. The book further discusses the reasons why adolescent girls may become emotionally unstable and possible and effective remedies for the same. It also delves deeper into how child marriage impacts overall physical, mental and emotional well-being of an adolescent girl.

- **(Harish, 2023)** highlights that adolescent mental health is a critical area because half of all adult mental health disorders often begin by age 14, making early recognition and intervention extremely crucial. It covers the epidemiology of common mental health disorders, risk factors on adolescents' mental health at individual, family, school, peer, and community levels. It also addresses specific issues such as stress, depression, anxiety, substance abuse, self-harm, suicidal behavior, and the impact of digital technologies, including social media use and gaming addiction. It urges a non-judgmental attitude towards the adolescents and to respect their privacy, and effective communication techniques. If any psychosocial history is found; healthcare providers should try to connect with adolescents and facilitate counseling. The inclusion of adolescent mental health in the MBBS Competency-based Medical Education (CBME) curriculum signifies its integral role in training future doctors to address the unique psychological needs and vulnerabilities of the adolescents.
- **(Skuse, 2011)** incorporates various dimensions of child and adolescents' psychology. The book throes light upon the family and systemic influences, sibling influences, genetic and biological influences on child's and adolescents' mentality. It further digs deeper into depression in adolescents and suicidal behavior as a result. It also suggests approaches to intervention by discovering psychiatric pharmacogenomics, Behvioural therapy, parenting programmes, systemic interventions among many other.
- **(Lerner & Steinberg, 2009)** show how the understanding of adolescents has really grown up over the past years. Instead of seeing adolescence only as a difficult, troublesome time or merely a stepping stone to adulthood (as earlier ideas, like G. Stanley Hall's, often suggested), this book presents a much more positive and entirety of the situation. It highlights that adolescents are active, smart, and capable individuals who are willing to make their own choices, think deeply, and navigate many influences around them – from family and friends to media and the surroundings. The book looks at all sides of adolescent development – from physical development to mental growth and emotional attachments with partners and family. It further investigates

how culture shapes them. It brings together ideas from many different fields including but not limited to psychology, to give a well-rounded view. Ultimately, the goal of the book is to use this in-depth scientific knowledge to create better programs and policies that support the healthy and positive development of adolescents everywhere.

1.1.1. Inferences drawn from the Review of Literature on Adolescent Mental Health

Adolescent mental health is a critical global concern, as shown by World Health Organization (WHO) which estimates 14.3% of mental health conditions globally, and the National Mental Health Survey of India (2016) showing a 7.3% prevalence in Indian adolescents, particularly higher in urban areas. These conditions, includes but is not limited to depression, panic attacks, anxiety, and behavioral disorders which are leading causes suicide. Suicide is the third leading cause of death among those aged 15–29, underscoring their severe impact on school attendance, academic functioning, and social behavior. Despite this high prevalence, a significant treatment gap persists, often ranging from 70% to over 90% in regions like Rajasthan, primarily due to stigma, shame, social exclusion, discrimination, limited access to care, and a general lack of dedicated child and adolescent mental health policies in many low- and middle-income countries, as highlighted by UNICEF, Sharma & Sharma (2025), and Zhou et al. (2020). The contributing factors to mental health issue in adolescents are multifaceted, incorporating familial issues like gender discrimination and family structure (Shergill & Rathore Hooja, 2025; Maheshwari et al., 2020; Ram et al., 2014), intense academic pressure and social isolation (S. Pal et al., 2025), and cultural beliefs and socioeconomic developments (Prabhu et al., 2023; Aggarwal & Berk, 2015). Research from India illustrates the influence of coaching demands, household dynamics, gendered expectations, stigma, inadequate counselling resources, and obstacles to help-seeking on teenage well-being. Urban centers such as Kota, the most Literate district of Rajasthan (Government of Rajasthan, 2025a) experience increased stress and elevated suicide risks, particularly among students in competitive coaching settings. Systematic reviews confirm that adolescent mental health is influenced by social, academic, and familial

circumstances, however current policies and treatments are disjointed and inadequate. Consequently, there is an urgent and consistent call across the globe for early intervention and comprehensive, advocating for national mental health strategies, school-based interventions, community support frameworks, and collaborative approaches involving healthcare professionals, parents, and teachers to foster resilience and ensure holistic adolescent development.

1.1.2. Research Gap

The current literature underscores the increasing prevalence of adolescent mental health challenges in India and worldwide, focusing on depression, anxiety, stress, loneliness, familial gender discrimination, detrimental academic settings, and insufficient support networks. International and national recommendations emphasise the necessity for rights-based, accessible mental health care, interventions at the school level, and frameworks for community sensitisation.

Despite extensive studies, significant gaps exist. Most of the local studies specifically focus on Kota, leaving Jaipur, the state capital. This study compares both the locations. Gap exists in Gender specific study. According to WHO, women are more susceptible to depression than men, yet no study (to the knowledge of researcher) has analyzed the mental health issues specifically focusing on female only. The study further investigates the intensity of mental health issues between students residing at home and those living independently in Jaipur and Kota districts of Rajasthan. The age-specific vulnerabilities of younger (15–17) and older (17–19) female adolescents further lack in-depth researches. Despite the prevalent mental health concerns, there is a severe gap between the issues and the help seeking behaviour. Hence the study aims to study the help-seeking behaviour among adolescents. This targeted comparative analysis examines a neglected junction of gender, location, age, mental well-being, adolescence and living conditions in the state of Rajasthan.

1.2. Postpartum Mental Health

a) Government Policies/Programs/Schemes

- (Rajya Sabha, 2025b)'s Q&A session from the Indian Ministry of Health and Family Welfare mentions efforts to improve maternal and newborn health under the National Health Mission (NHM). The National Health Mission's Janani Suraksha Yojana and Pradhan Mantri Surakshit Matritva Abhiyan provide free and high-quality healthcare to mothers and babies. For better maternal and child health, ASHAs and Village Health Sanitation and Nutrition Committees should engage the community. Tuberculosis, malaria, and Kala-azar cases have decreased due to improved control. With millions of hospital admissions and maternal and child health packages, the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) has increased health coverage.
- **(Central Mental Health Authority, 2017)** The Mental Healthcare Act, 2017 (MHCA) is a guidance manual that covers mental healthcare and therapy for all. It protects their dignity, rights, and mental health through a rights-based approach. In order to prioritise the mental illness patients' choices and respect their treatment decisions, the Act emphasises placing them at the care-center. It regulates mental health care, admission, discharge, and continuous monitoring by authorities help and protect these individuals. The manual although emphasises emotional support and mental health needs for mothers after delivery, it does not detail on postpartum care procedures. The manual recommends awareness, respectful support, timely intervention, health- carer involvement, and access to mental health services for postpartum women with mental health challenges, within the rights-protecting framework of the MHCA.
- **(Ministry of Health and Family Welfare, 2016)** The Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) mandates every pregnant woman to get at least one complete antenatal check-up by a doctor or specialist in the second or third trimester to increase quality and coverage. Early identification and scheduling of high-risk pregnancies allows birth planning and complication preparation. It emphasises public-private partnerships,

allowing authorised private health institutions and voluntary obstetricians to provide free antenatal services on the appointed day and refer high-risk cases to government facilities. To ensure the abhiyaan's success, a robust reporting and monitoring system includes beneficiary line listing and monthly facility-to-state and central reporting. For smooth implementation, facility readiness requirements include logistics, staff roles and duties, suitable infrastructure, and targeted communication.

- **(Ministry of Health and Family Welfare, 2015)** Mental health activities at the district level under the National Mental Health Programme (NMHP) during the 12th Plan period addresses mental health issues including severe mental disorders (SMD), common mental disorders such as depression, anxiety, substance abuse, conduct disturbances, and psychosocial problems among out-of-school children and college students. A district-level integrated approach with outpatient (mental health services provided to patients who visit the facility for consultation, diagnosis, treatment, and counseling but do not need overnight stay), inpatient (one who stay in the facility and need continuous attention, care and monitoring), community outreach, and follow-up care by psychiatrists, clinical psychologists, and social workers is recommended. Early identification and referral require medical officers, health workers, and school and college teachers to be trained, as well as psychosocial interventions like counselling, psychoeducation, and rehabilitative support. Awareness initiatives, IEC (Information Education and Communication) activities, Non-Governmental Organisations' help and social benefits promote community engagement. The program also recommends establishing helplines and day care centers for continued support and relapse prevention.
- **(Ministry of Health and Family Welfare, 2014)** National Mental Health Policy promotes mental health, provides guidelines to prevent mental illness, ensures accessible and quality mental health services, promotes socio-economic inclusion of people with mental illness as a rights-based approach. Equity, integrated care, reducing the stigma attached to it, reform(s) of the mental health institutions, carer support, and vulnerable populations like the

homeless and chronically ill are the priorities. The strategy encourages community involvement, research, and leadership and management mechanisms to improve mental health governance in India.

- **(Ministry of Health and Family Welfare, 2005)** The Accredited Social Health Activist (ASHA) plan under the National Rural Health Mission promotes rural health by raising awareness and improving access to health services for vulnerable women and children. ASHAs, selected from the community and trained in an integrated, collaborate with Anganwadi Workers, Auxiliary Nurse Midwives (ANMs), and Panchayats to mobilise beneficiaries for immunisation, safe delivery, and health check-ups. They receive performance-based pay for basic curative care, health education, and referrals. Through community engagement and better health systems, the goal is to improve health and reduce mother and child mortality.

b) Research Papers

- **(Behl et al., 2025)** investigated clinical specialists' views on the efficacy of legislative initiatives in treating perinatal depression (PND) in India. The research focusses on the lack of frequent mental health screening and insufficient policies that fail to incorporate Perinatal Mental Health. It advises modifying the Mental Health Care Act of 2017.
- **(Kirpekar et al., 2024)** argues that the District Mental Health Program (DMHP) has grown and changed since 1996 to close India's mental health treatment gap by integrating mental health services into primary care and encouraging community participation. Government studies, the National Institute of Mental Health and Neurosciences (NIMHANS) and the National Human Rights Commission (NHRC) reviews, policy analyzes, and latest data on DMHP coverage in 738 districts provide evidence. Evaluation shows gains in service accessibility, telepsychiatry, and legal safeguards under the Mental Healthcare Act 2017. But still, there are ongoing difficulties such insufficient mental health workforce, financial transparency, and legal and infrastructural hurdles. More monitoring, training, resource allocation, and

policy implementation are needed to strengthen the program and ensure equal access is recommended in this paper.

- **(Das & Yadav, 2023)** review the India's RMNCH+A strategy (2014) which reveals limited progress in reducing neonatal mortality rates (NMR) in high-burden states, including Rajasthan, which, along with Madhya Pradesh, Uttar Pradesh, Chhattisgarh, and Odisha, is unlikely to meet the UN SDG target of 12 NMR by 2030 if current trends continue.
- **(Lodha & Sousa, 2022)**'s editorial from the *Annals of Indian Psychiatry* examines postpartum depression (PPD), its prevalence, effects, and associated challenges, especially within the context of India and the COVID-19 pandemic. It brings to light that approximately 22% of mothers worldwide encounter postpartum depression, which considerably impacts the health and development of both mothers and infants. The paper highlights the significance of universal screening, prompt identification, integrated healthcare systems, and the active participation of mental health professionals to address treatment disparities.

This expert editorial examines postpartum depression.

- **(Poreddi et al., 2021)** studied 279 postpartum mothers in India and determined that merely 50.7% had any awareness regarding postpartum depression. Significant correlations were identified between postpartum depression, literacy rate of mothers and maternal age, income level, and employment status, with older, higher-income, and employed mothers demonstrating higher scores. Most mothers demonstrated limited awareness of the primary symptoms and risk factors associated with postpartum depression, including persistent sadness and genetic issues. Although healthcare professionals constituted the primary source of assistance, a significant minority requested aid from traditional or spiritual healers. The study emphasised the critical importance of raising awareness among women.
- **(Sagar et al., 2020)** uses data from different sources within the Global Burden of Diseases framework to give a thorough assessment of the prevalence and disease burden of mental disorders in all states of India

between 1990 and 2017. It found out that one in every seven Indians suffers from mental problems, with the burden virtually doubling throughout this time span. Adult-onset disorders are more common in developed south-Indian regions, whereas childhood/adolescent-onset illnesses are more prevalent in less developed northern areas.

- **(Arora & Aeri, 2019)** did a systematic review and examined eight studies from northern, western, and southern India with prevalence rates of Postpartum depression from 9.18% to 65% to determine the burden and risk factors in pregnant Indian women. Various risk factors were identified. The review shows little research in the eastern Indian, limiting generalizability. It advises the healthcare workers to be aware and vigilant about the issue.
- **(Upadhyay et al., 2017)** discuss how postpartum depression (PPD) is a major maternal mental health concern in India. The detailed review and meta-analysis of 38 studies including 19,455 women indicated a 22% astonishing prevalence of PPD. Data was heterogeneous. The high prevalence of Depression in India highlights the need for improved maternal mental health policies, preventive and curative measures and capacity-building, including guidelines and financial allocation. This analysis recommends immediate governmental action to include mental health into postpartum treatment in India to improve the mother's and child's health.
- **(Uppadhaya et al., 2016)** analyzed the community-based post-natal care in rural Western Rajasthan which involved 198 women who delivered between July 2013 and June 2014. Study found that merely 35.86% of mothers completed two or more postnatal visits within 42 days postpartum, with lack of knowledge and awareness identified as the main reason for this irresponsibility, highlighting the importance of improving access to health facilities, implementing awareness campaigns, and motivating service providers to enhance maternal and neonatal health care system.
- **(Nigam et al., 2016)** identified a significantly high prevalence (93%) of postpartum depression among women in regions surrounding Lucknow. Factors contributing to Postpartum depression included child care stress (94%), life stress (90%), low self-esteem (82%), limited social support

(81%), neonate temperament issues (78%), and low socioeconomic status (77%). The majority of women (89%) experienced five or more contributing factors concurrently.

- (K. Iyengar et al., 2012) emphasized that severe maternal problems following delivery increase the risk of sickness and death in the first year postpartum. Up to 12 months after childbirth, the mothers face higher psychological disorders, especially postpartum depression, and pressure and struggle to resume home chores and self-care. Some face high debt and catastrophic expenses. The research points out that such needs exceed cash-transfer programs, showing a need for financial and health help. The study highlights the need for regular, thorough follow-up care for women up to a year postpartum to address physical, mental, psychological, and economic issues.

c) Books

- (Kanfade, 2024) presents unique challenges faced by women in choosing a life partner and its impact on their mental health. The books not only discuss the possible mental burden she feels while selecting a partner but also offers solutions for the same to encourage healthy boundaries in relationships to maintain good mental health. The mental health of women takes a toll while navigating through motherhood. The author untangles every social and personal aspect from delay in conceiving due to career opportunities, infertility to abortion. Then he also delves deeper into three major types of mental health issues which includes postpartum blues, depression and psychosis - their definitions, causes, prevalence, symptoms, diagnosis, prognosis, complications and management.
- **(Sedgwick et al., n.d.)** have designed the workbook, titled "Gaining Control of your Life after having a baby," women who are experiencing mild to moderate depression during or after pregnancy. The workbook is also beneficial for those recovering from a severe depressive episode. This also benefits the mother's supporters. Cognitive behavioral therapy (CBT) is explained in detail which provides practical, evidence-based techniques to

manage moods by changing thoughts and behaviors. It guides needful mothers to understand postnatal depression, set goals accordingly, self-monitor, and implement strategies to alter behavior and thinking. It also emphasizes that recovery requires consistent practice and determination, suggesting an 8–12-week program to learn and apply techniques like time management, problem-solving, stress reduction, and activities to improve mood and regain control of one's life.

- (María Castillo, 2012) in their book contribute to a better understanding and detection of postpartum mental health issues such as anxiety and depression. It further explores its negative impact on the mother-child relationship. Ten different essays on Postpartum mental health discusses the biological, psychological, and social foundations of these conditions, acknowledging that while effective psychological and pharmacological treatments exist, postpartum depression remains under-detected and under-treated most of the times. The book also broadens its scope to include postpartum depression in fathers and also extends its attention to specific vulnerable populations such as minorities, immigrants, and rural communities who suffer the same.

1.2.1. Inferences drawn from the Review of Literature on Postpartum mental health

While India has well established broad government initiatives like the National Health Mission (NHM), Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA), and the Mental Healthcare Act, 2017 (MHCA) to address maternal health, these policies often lack precise, detailed provisions for the mental health care of mother after giving birth. The MHCA, for instance, recommends support for postpartum women but does not provide any specific care protocols. Various research indicates a high prevalence of postpartum depression (PPD) in India, with estimates ranging significantly, and notably high figures like 22% nationally and up to 93% in specific regions. Despite the issue, there is alarmingly low awareness among mothers and in general public regarding PPD symptoms and risk factors, with only about half of postpartum mothers possessing any knowledge about the condition. This gap in awareness contributes to under-detection and under-treatment. Studies highlight

various socio-economic and personal risk factors for PPD, including lower literacy rates, maternal age, income level, employment status, child care stress, life stress, low self-esteem, limited social support, neonate temperament issues, and low socioeconomic status a few among numerous other reasons for PPD. Programs like the National Mental Health Programme (NMHP) aiming for district-level mental health services exist but not without its own flaws. Because significant challenges persist in its effective integration into primary care, and community participation. An insufficient mental health workforce, financial transparency issues, and infrastructural hurdles are few among many. Additionally, the lack of frequent mental health screening for mothers and inadequate policies that fail to fully incorporate postpartum mental health are critical deficits. It is also important to note that although researches have been done on postpartum mental health, the research still doesn't cover entire nation. India is a diverse nation and Postpartum depression can stem from various cultural and social reasons. A reason that may become cause for postpartum depression in one region may not be an issue in other part. Hence, customized policies and programs are required for a vast country such as India where issues change its form and course with caste, class, region, gender and overall surrounding.

1.2.2. Research Gap

Numerous research has been done on Postpartum mental health throughout the globe. The researches have been done from various point of views such as Psychology, Medical science, etcetera but integrating the issues with Administration has not been researched deeply and consistently.

The guidelines for Accredited Social Health Activists (ASHA) although physical health issues like antenatal care, immunisation, diet, sanitation, family planning, and common sickness management, it fails to address mental health or postpartum maternal mental health. As a community health activist who counsels and facilitates access to health care, ASHA may be able to integrate mental health knowledge and support into her position yet there is no specific guideline to train them for the same. National Mental Health Policy (2014) also does not address the Postpartum mental health and related mother mental health issues. National Mental Health Program

(2015) too fails to discuss postpartum depression or any other mother mental health difficulties and care. The main focus is general mental health services. Pradhan Mantri Surakshit Matritva Abhiyaan (2016) though discuss Antenatal care, managing high-risk pregnancies, infection prevention, pregnancy care counselling, birth preparedness, complication readiness, and postpartum family planning but postpartum **mental** health issues such as postpartum blues, postpartum depression and postpartum psychosis and its screening, counselling, or management and treatment are not a part of the Abhiyaan. The National Health Mission's Janani Suraksha Yojana and Pradhan Mantri Surakshit Matritva Abhiyan's focus remains on comprehensive physical healthcare and community-based support systems and fails to address the mental health issues faced by the mothers. Many research has been done on the issue but without integrating the issue- symptoms, causes, treatment with Government policies, the issue with persist; both in the mothers and in the system as well.

All the aforementioned Government Policies barely touch mental health issues of mothers. It solely focuses on physical health. Moreover, research has not been done from the healthcare workers like Doctors' and psychologists' point of view in the State of Rajasthan, specifically Kota and Jaipur districts. These are the people who are trained and experts in diagnosing the patients. A patient may give only her opinion but a doctor is in contact with many patients and can provide better insight into this urgent medical issue that is being constantly ignored and overlooked by the policy makers. Also, Rajasthan poses unique challenges as compared to other states of India. District specific study can only reveal unique reasons and solutions of the issue.

This research is an attempt to fill this research gap through utilizing opinions of doctors (gynecologists) and Psychologists in the state of Rajasthan; specifically in Jaipur and Kota districts.

1.3. Education for differently-abled female

a) Government Policies

- **(Ministry of Education, 2020) National Education Policy, 2020** highlights a thorough strategy for fostering inclusive education for children with disabilities, referred to as "Divyang" in India. This is in harmony with the 2016 legislation that promotes inclusive education, ensuring that all students, regardless of their abilities, can learn side by side in a flexible setting through various means, including specialised devices, tech tools, and learning resources that are accessible, such as Braille textbooks and large print materials. Creating effective educational modules for teaching Indian Sign Language and fundamental subjects through sign language, aimed at enhancing communication and learning experiences for children with hearing challenges. Hiring specialised educators with diverse training and assisting schools in implementing customised accommodations for different disabilities.
- **(Ministry of Law and Justice, 2016) Rights of Person with Disability Act, 2016** highlights the significance of delivering inclusive education for those with disabilities, guaranteeing their equitable access to educational opportunities. It requires accessible educational facilities, specialised assistance, and skilled educators to address their requirements. The legislation emphasises provisions for the early identification of disabilities and adaptations for inclusive classrooms. Furthermore, it promotes engagement, social advancement, and equitable rights throughout all facets of life, encompassing employment, accessibility, and communal living.
- **(Ministry of Social Justice and Empowerment, 2015) Sugamya Bharat Abhiyaan, 2015 (Accessible India Campaign)** brings out the significance of delivering inclusive education for those with disabilities, guaranteeing their equitable access to educational opportunities. The main focus is on the accessible educational facilities, specialised assistance, and skilled educators to address their demands. The legislation mandates provisions for the early identification of disabilities and adaptations for inclusive classrooms. Additionally, it promotes engagement, social advancement, and equitable

rights throughout all facets of life, including employment, accessibility, and communal living. The emphasis is on guaranteeing that individuals with disabilities obtain equitable education and chances for comprehensive society engagement.

- (Ministry of Education, 2019, 2020, 2021; Ministry of Human Resource Development, 2017, 2017) The All-India Survey on Higher Education (AISHE) provides a representation of higher education in India by gathering data from all higher education institutions. It contains multiple aspects, including enrolment, infrastructure, faculty, and programs, to facilitate informed policy-making. The survey seeks to rectify deficiencies in current data sources by incorporating a variety of stakeholders and institutions nationwide. Administered annually via an electronic platform, it facilitates trend monitoring, evaluates educational progress, and guarantees transparency in higher education.

AISHE reports have not been generated since 2022.

b) Research Papers

- **(Jardinez & Natividad, 2024)** studied that inclusive education helps everyone by promoting brotherhood and equal opportunity. But there are greater issues, such as not having enough resources and lack of trained teachers, that make it difficult to fully implement. Focussing on educational ideas can help make modifications that make inclusion more effective. To fully utilise the potential of inclusive education, researcher suggest to work together on policy, training, and resource allocation to make equity happen.
- **(Chatzitheochari & Butler-Rees, 2023)** researched in the schools of England, concentrating on disabled students across diverse regions, including the Midlands, North, and South of England. They examined the influence of intersecting elements of disability type and socioeconomic class on the experiences of stigma among handicapped youth in mainstream educational settings. Evidence from semi-structured interviews indicates that social class substantially impacts the support pupils receive and their status within the school, hence influencing their experiences of stigma. The study reveals substantial gaps in stigma depending upon the recognition and impact of

disability, in addition to socio-economic background. It emphasises the significance of intersectional analysis in comprehending disability-related stigma and highlights discrimination in education and social inclusion.

- **(Ghosh et al., 2022)** focusses on analysing intersectional prejudice faced by women and differently abled girls with disabilities about educational possibilities in India. The research was driven by enduring obstacles connected to gender and disability in attaining inclusive education. It has used the National Sample Survey data and regression analysis to demonstrate diminished enrolment and accomplishment among women with impairments. Results indicate substantial gender-based differences, with women encountering further prejudice. The finding underscores the necessity for focused, inclusive strategies to tackle these intersecting inequities and enhance equitable educational access for women with disabilities.
- **(Vadivelan et al., 2020)** present case of Carers of children with cerebral palsy in Tamil Nadu who encounter complex stressors stemming from socio-cultural, economic, and environmental influences. The study identified physical discomfort, feelings of remorse, financial strain, social isolation, discrimination, unsafe public environments, and insufficient government assistance as primary sources of stress. The findings of this study underscore the interconnectedness of gender, poverty, and stigma that intensify carer burdens, revealing systemic deficiencies in public health policies and social support frameworks. Tackling these requires policy reforms, robust community support systems, and inclusive public infrastructure to enhance caregivers' quality of life.
- **(Onyishi & Sefotho, 2020)** focusses on the viewpoints of primary school educators in Enugu State, Nigeria, concerning the implementation of differentiated instruction (DI) in inclusive classrooms. Research indicates that educators infrequently employ differentiated instruction methodologies comprehensively due to limitations including insufficient time, large class sizes, poor educational resources, and restrictive classroom settings. Although several educators employ pre-assessment with more frequency, alternative differentiated instruction strategies such as flexible grouping and

diverse instructional materials are seldom utilised. Teachers recognise the significance of differentiated instruction (DI) but identify various structural and practical obstacles that impede its comprehensive implementation, underscoring important ramifications for teacher education and policy.

- **(Singal, 2019)** critically examines the evolution of inclusive education in India, highlighting its growth in the enrolment of children with disabilities, propelled by progressive legislation and outside influences such as the Salamanca Statement. Nonetheless, considerable obstacles persist, such as low transition rates beyond elementary education, insufficient resources, substandard teaching quality, and systemic challenges that restrict authentic involvement and acknowledgement of marginalised populations. Obstacles like societal prejudices, power disparities, and insufficient genuine involvement with educators and families impede the full realisation of inclusive education's potential. The analysis underscores the necessity of transitioning from just enhancing access to tackling profound social, institutional, and cultural obstacles that hinder the establishment of genuinely inclusive and equitable learning environments.
- **(Palmer et al., 2017)** conducts a study using data from the Educational Longitudinal Study (ELS) by the National Center for Education Statistics, explores the impact of high school extracurricular activities on postsecondary degree completion among students with disabilities in the United States. The findings reveal a significant positive association between participation in school-sponsored extracurricular activities during Grade 12 and the likelihood of completing a postsecondary degree for students with disabilities. The research emphasizes the importance of accessible and encouraging extracurricular opportunities for students with disabilities, suggesting that such engagement can improve academic outcomes and help close the attainment gap between students with disabilities and their nondisabled peers.
- **(Dean et al., 2017)** explores the diverse experiences of differently-abled women in Gujarat, India, focusing on their sexual and reproductive health rights through an intersectional view point. The research includes in-depth

qualitative interviews highlighting how the factors like disability type, socio-economic status, and social norms shape their access to SRH (sexual and reproductive health) services and autonomy. This emphasizes that recognizing heterogeneity among disabled women is vital for their empowerment. The findings show that disabled women face intersectionality of discrimination, social exclusion, and barriers to healthcare, highlighting the need for urgent strategies to address these issues.

- **(Naraharisetti & Castro, 2016)** examines job prospects for disabled people in India using 2001 Census data. In rural areas, mental disabilities hinder employment, while being female or having movement or sight impairments increases it. In urban areas, being female or illiterate decreases employment chances, while sight, mental, and movement disabilities increase them. To promote inclusive employment in India, the research recommends spatially focused and disability-specific policy interventions that address local and disability-related barriers.
- **(Gillborn, 2015)** analyzes intersectional dimensions including race, class, gender, and disability in relation to educational disparities. The report recognises gender as a significant factor, particularly Black male students, emphasising challenges such as segregation, increased monitoring, victimisation, and exclusion from mainstream services. This research examines the challenges faced by Black middle-class parents in fighting for their children's needs within the predominantly racist institutions, focussing specifically on Special Educational Needs (SEN) and discriminatory behaviours.
- **(Philip, 2015)** focusses on identifying factors that impact the living opportunities of girls who are differently-abled in rural India (South India, in this study) and examining sustainable strategies to enhance their autonomy. A semi-structured interviews indicates that parental worries, insufficient opportunities, and diminished self-esteem are significant obstacles, in collaboration with literature on disability and gender marginalization. The assessment highlights the significance of awareness initiatives, counselling, and home-based education as efficacious interventions. The study indicates

that to improve the self-sufficiency of girls with impairments in rural regions, home based tuitions, counseling, etc. (coordinated efforts) can be used, which is context based, mostly.

- **(Dawn, 2014)** analyzes the significant occurrence of sexual violence against women with disabilities in India, emphasising sociocultural vulnerabilities and insufficient legal safeguards. Evidence indicates that the majority of offenders are male members nevertheless, thorough data is lacking. The study indicates that current legislation and support frameworks are inadequate, highlighting the necessity for accessible grievance procedures, legal reform, and increased awareness to safeguard and empower women with disabilities.
- **(Bhatnagar & Das, 2014)** investigates secondary school teachers in New Delhi, India's concerns and perceived hurdles to inclusive education for disabled children. The research finds three main issues: inadequate infrastructure, low financial resources, and excessive class sizes, based on focus group and semi-structured interviews with inclusive school teachers. These problems stem from infrastructural issues like ramps and assistive technologies and resource limits that prevent special education kids from getting the tools they need. The survey also found eleven thematic hurdles, including a lack of skilled staff, inclusion policies, and instructional differentiation. According to worldwide research, teacher preparedness and resource availability are crucial to inclusive education. The report emphasises the need for policymakers to address these issues completely, including professional development, infrastructure upgrades, and enough funding to increase inclusion and educational success for children with disabilities. The research adds to India's limited qualitative studies by revealing Delhi's complicated classroom dynamics affecting inclusive education.
- **(Liasidou, 2013)** examines how intersectional frameworks enhance the awareness of disability by emphasising its interrelation with other social disadvantages, including race, gender, and social class. The study highlights the shortcomings of conventional, reductionist approaches to disability that

concentrate exclusively on individual pathology, advocating for the necessity of a social justice framework that confronts institutional injustices and power disparities in educational settings. It promotes transformative reforms that acknowledge the fluid and intersectional characteristics of identities and experiences, urging policymakers and educators to adopt systemic, multilayered strategies to actively dismantle institutional barriers and cultivate inclusive, equitable learning environments. The author emphasises that intersectionality is essential for understanding disability in a manner that fosters social justice and facilitates successful policy responses addressing different forms of oppression concurrently.

- **(V. B. Gupta et al., 2012)** explores the intensity of parenting stress among parents of differently abled children in India. The research shows that parents specifically of girls, those engaged in important occupations, experience higher stress, often due to unmet expectations and social pressures, with limited family support and reliance on religious coping mechanisms. The study highlights the need for formal support systems and further exploration of socioeconomic factors. The findings reveal significant stress across various class, emphasizing the importance of targeted interventions to support these parents in every class.
- **(G. C. Pal, 2011)** highlight considerable gender disparities among individuals with disabled female from marginalized groups such as Dalits, facing increased vulnerability. In comparison to men, differently abled women are more married and suffer social and economic disadvantages due to the intersection of gender, caste, and disability characteristics. This led to social exclusion and impoverishment, highlighting the necessity for gender-sensitive and caste-conscious policies to foster social justice and inclusive development.
- **(Staples, 2011)** employed ethnographic fieldwork - characterized by comprehensive, immersive observations and discussions with disabled males in India to collect the data. He specifically examined men afflicted by leprosy and cerebral palsy throughout several communities. The engagements within communities such as Bethany, a leprosy colony, as well

as in wider urban environments in Hyderabad exhibited that men display masculinity through resilience, humour, or the fulfilment of conventional roles despite their disabilities. The researcher discovered the impact of social context on notions of masculinity. The researcher identified situations in which disabled men contested or reinterpreted masculinity, occasionally embracing their limitations.

- **(Bouck, 2010)** discusses how life skills teaching helps individuals with intellectual disability (ID) move from school to adulthood in the United States. Despite overwhelming evidence that life skills programs increase employment, independence, and community participation, schools rarely use them, especially for mild ID kids. The study shows that academic requirements have replaced functional life skills training in education. The paper also examines the controversy surrounding functional curricula in inclusive education policies like No Child Left Behind Act (NCLB) and Individuals with Disabilities Education Act (IDEA). It emphasises the need for more research on life skills education and postschool results and calls for greater integration of life skills training to better prepare ID students for independent living and work after high school.
- **(M. Cooper & Alvarado, 2005)** examines teacher training, recruiting, and retaining. In order to improve the supply of teachers and reduce attrition from teacher education, in difficult-to-staff schools especially, it is important that a more coherent policy framework be developed which links these stages with national and local needs for quality education. The research emphasizes that the primary criterion for good teacher preparation should be high standards, extensive pedagogical coursework, and meaningful clinical practice. Recruitment plans should concentrate on varying access routes from high school, incentivizing and partnering. Intrinsic motivation, administrative support and work environment highly affect retention, whereas induction and mentorship programs provide great help to beginning teachers. The paper reinforces that teacher quality and stability can be achieved only through a comprehensive strategy.

c) **Books**

- **(Jain & Sharma, 2022)** discusses the Education and Institutional Buildings in the 4th chapter of the book. The writers take a historical lens and discuss the foundation of education for women in Rajasthan beginning from great historical figure Rassundri Devi. They further elaborate the struggles Rajasthan women faced to get access to education and gain historical significance. Various struggle stories of heroines are elaborated and the initiatives taken for women's education in Jaipur has been discussed in detail. Formation of Banasthali Vidyapeeth, institutions in Mewar, Jodhpur and other parts of Rajasthan has been dealt in detail.
- **(Jamwal & Silvest, 2022)** comprehensively examine the status, challenges, and transformative power of women's education in India, from ancient times to the 21st century. The authors found out that despite the government's commitment to education, India still faces significant challenges especially with female literacy rates, which negatively impact women's lives, their families, and therefore the nation's economic development. They argue that to empower women in India, education is crucial. Education will also eliminate inequalities, and foster socio-economic progress by providing women with strength, autonomy, and the ability to contribute significantly to society. It delves into various contemporary issues including but not limited to persistent gender discrimination, sociological drawbacks in higher education, societal pressures, economic dependence, lack of decision-making power, gender bias in curriculum, regional disparities etcetera. It also discusses government schemes like '*Beti Bachao Beti Padhao*' aimed at promoting female education and empowerment for quality education as a fundamental tool for achieving women's empowerment.
- **(Central Board of Secondary Education, 2020)** emphasizes attitudinal restructuring. It involves changing mindsets and perceptions among all stakeholders who are involved in the inclusive education which includes parents, teachers, relatives, and the community, to eradicate barriers that hinder inclusive education. There are many myths surrounding inclusive education. Common myths include that segregation is better, inclusive

education is an expensive option; these beliefs also include that inclusion is difficult in regular schools and parents are non-cooperative and the worse that people with disabilities are a societal burden. To achieve educational success, inclusive education must believe that every child can learn and realize their full potential when provided equal opportunities, appropriate resources, and instruction tailored to their needs in a least restrictive environment. Therefore, there is a need to adjust the school system to diverse needs, and ensure continuous teacher training and strong partnerships with parents.

- **(Kataria & Parihar, 2017)** present a compilation of various articles on Women's empowerment. Various dimensions of Women's Empowerment in India are discussed in detail which includes but is not limited to social justice and ethics of scriptures, feminist parenting, various legislative initiatives to empower women such as amendments in the Panchayati Raj system, surrogacy in India, triple *talaq* in Islam, anti-violence schemes. Feminism is dealt deeper through addressing the challenges faced by women in science, entrepreneurship, political participation, etc.
- **(Craven et al., 2015)** in their book identify international strategies, proved and effective theories, relevant research, thoughtful policies, and practices that promote successful education and positive psychosocial development for students with who are differently-abled. The book distinguishes itself by offering a truly global perspective, bringing together thirty-one scholars from a wide variety of research areas and ten different countries to provide global context of the narrative. Rather than merely justifying inclusion, the book explicitly addresses *how* to build effective inclusive learning environments through '*continuously becoming*' and to make them competitive, ensuring individuals with intellectual disabilities get opportunities to become respected citizens. It further focuses on empirically-assessed practices from across the world, fostering self-determination by prioritizing the voices of students with intellectual disabilities, and examining the critical roles of parents and educators in imparting knowledge.

- **(Julka, 2015)** provides a practical guide for regular classroom teachers, focusing on how to make their classrooms and teaching truly inclusive for students with special needs. It addresses the equal rights for all children, including those who are differently abled, to quality education and full participation in the learning process. It addresses teachers' apprehension in teaching special children with regular ones and provides a shift from only placement to Active Participation and Subject-Specific Strategies to children who need special attention among many other solutions to make them feel equal, as it is provisioned in the Constitution of India.

1.3.1. Inferences drawn from the Review of Literature on Education for Divyang Women in Rajasthan

Numerous efforts have been made concerning the education and upliftment of differently-abled students in India. It includes focus on establishing supportive legislative frameworks, conducting various research on intersectional barriers, providing accessible tools among many. In India, government policies, like the National Education Policy (NEP) of 2020 and the Rights of Person with Disability Act of 2016 mandate inclusive education, ensuring equality, accessible facilities for all, specialized assistance, and the hiring special educators for all children with special needs, referred to as 'Divyang'. The Sugamya Bharat Abhiyaan (Accessible India Campaign, 2015) also highlights the importance of accessible educational facilities. Research also underscores the importance of useful life skills education along with the academic curriculum which will be essential for the autonomy and career opportunities of students with mental disabilities. Intersectionality serves as a crucial issue, illustrating how gender, caste, disability, and socioeconomic position amalgamate to ascend disadvantages for differently-abled women, especially from marginalised communities, increasing their susceptibility to social exclusion, illiteracy, poverty, violence and other similar issues.

Research specifically targeting differently-abled women in India has highlighted the critical issue of intersectionality (gender and disability) (Ghosh et al., 2022). Studies have also revealed that factors like socio-economic status, disability type, and social norms profoundly shape their access to sexual and reproductive health services and

autonomy, highlighting the importance and need of recognizing the heterogeneity among divyang women for their empowerment (Dean et al., 2017).

Various other studies and researches have collectively emphasized the necessity of targeted support and systemic changes to improve the autonomy and educational outcomes for differently-abled women. Practical efforts proposed in various research include awareness initiatives, counselling of both parents and students, and context-based interventions like home-based education and tuitions to overcome parental worries, insufficient opportunities, and diminished self-esteem, especially in rural settings (Philip, 2015). Long term change should emphasize transitioning from merely providing physical assistance to tackling profound cultural, institutional, and social obstacles that may hinder inclusion (Singal, 2019). The overall literature highlights that while legislative frameworks are in place, the true realization of equitable education requires addressing intersecting inequities, enhancing legal safeguards against vulnerabilities like sexual violence (Dawn, 2014), and ensuring targeted interventions to support their societal mindset (Ghosh et al., 2022; Philip, 2015).

1.3.2. Research Gap

Many research has been done on the education for Divyang students in India. Yet, a huge gap exists. It is imperative to note that region, gender, caste, class, society have effect on the education of Divyang women in India. There has been a decline in the enrolment of female students in Higher education since 2017 (AISHE Reports) in Rajasthan. Region and gender specific study has not been done in districts like Jaipur and Kota, especially focusing on the reasons of the decline of enrollment of female students in the higher education. This study covers this gap by finding and analyzing the probable reasons for the decline.

It also aims to understand various barriers to education specifically for female Divyang students including Physical, Social, Cultural barrier etcetera. It also aims to understand the security reasons because of which students' enrollment rate is declining in Rajasthan.

The research also fills the gap by understanding the views of special educators on inclusive education and whether or not it is suitable for students with special needs; as advised in the NEP 2020 in the state of Rajasthan particularly in Jaipur and Kota districts.

III

1.4. Research Objectives

1.4.1. Adolescent mental health of female students in Jaipur and Kota districts of Rajasthan

- To find out **Frequency of overwhelm** among female adolescents in Jaipur and Kota districts of Rajasthan.
- To analyze the **prevalence of Mental health symptoms** such as Anxiety, Loneliness, Panic Attacks, persistent sadness and suicidal thoughts in female students aged between **Jaipur and Kota districts**.
- To analyze the **prevalence of Mental health symptoms** such as Anxiety, Loneliness, Panic Attacks, persistent sadness and suicidal thoughts in female **students aged between 15-17 and 17-19**.
- To analyze the prevalence of **Mental health symptoms** such as Anxiety, Loneliness, Panic Attacks, persistent sadness and suicidal thoughts in female students **studying from home and away from home**.
- To compare the **mental health issues prevalence and help-seeking behaviour** for the same in female adolescent students in Jaipur and Kota districts.
- To understand how satisfied female adolescent girls are with the **administrative support provided by the local, state and National Government for the mental health issues and academic stress**.

1.4.2. Postpartum mental health in Jaipur and Kota Districts of Rajasthan

- To understand **Family related factors** that cause post-partum mental issues in the mothers of Rajasthan.
- To analyze the **Delivery related issues** that creates in post-partum mental health issues in the mothers of Rajasthan.

- To analyze the **societal and the cultural expectations** on Maternal Mental health.
- To find out how many healthcare providers belief **that cultural issues impact** Postpartum mental health recognition and treatment.
- To investigate an estimate of **clinical diagnosis rate of postpartum depression**.
- To interrogate from the healthcare professionals on how aware a Rajasthani mother is regarding mental health services and what is the **Help-seeking rate**.
- To inquire from the healthcare professionals about general **Public Awareness and Support System provided to the mother**.
- To understand how **literacy rate is associated with the awareness of postpartum mental health**.
- To understand the **role of healthcare providers**, Government (local, state and central) in managing postpartum mental health issues.
- To investigate **the long-term effect of Post partum mental health issues** as perceived by the healthcare providers on the women's future.

1.4.3. Education for Differently-abled female in Jaipur and Kota Districts of Rajasthan

- To analyze the **declining enrollment of Divyang female students in higher education institutions in Rajasthan** (AISHE Report 2017-2022) and identify the underlying causes from educators' perspectives.
- To evaluate the **awareness, effectiveness, and grassroots-level implementation** of government policies and schemes among educators (including Sugamya Bharat Abhiyaan, RPwD Act 2016, and NEP 2020) for the education of differently-abled female students.
- To identify and analyze the **attitudinal barriers** preventing differently-abled female students from accessing quality education in Jaipur and Kota districts of Rajasthan.

- To identify and analyze the **societal barriers** preventing differently-abled female students from accessing quality education in Jaipur and Kota districts of Rajasthan.
- To identify and analyze the **economic barriers** preventing differently-abled female students from accessing quality education in Jaipur and Kota districts of Rajasthan.
- To identify and analyze the **physical barriers** preventing differently-abled female students from accessing quality education in Jaipur and Kota districts of Rajasthan.
- To investigate the **severity of safety concerns** faced by differently-abled female students that is being a hindrance in seeking education.

1.5. Hypotheses

1. Hypothesis Related to District wise Differences (Jaipur and Kota)

1.1. Frequency of overwhelm

H₀: There is no significant difference in the frequency of overwhelm among female adolescent students between Jaipur and Kota districts.

H₁: There is a significant difference in the frequency of overwhelm among female adolescent students between Jaipur and Kota districts.

1.2. Academic Stress levels

H₀: There is no significant difference in the academic stress levels among female adolescent students between Jaipur and Kota districts.

H₁: There is a significant difference in the academic stress levels among female adolescent students between Jaipur and Kota districts.

1.3. Mental Health Indicators

H₀: There is no significant difference in mental health indicators* among female adolescent student between Jaipur and Kota districts.

H₁: There is a significant difference in mental health indicators* among female adolescent student between Jaipur and Kota districts.

***Tests will be conducted for each mental health indicator (Anxiety/Excessive Worry, Loneliness, Panic Attacks, Persistent Sadness or Hopelessness, Suicidal Thoughts) separately.**

1.4. Help-Seeking Behavior

H₀: There is no significant difference in help-seeking behavior* among female adolescent student between Jaipur and Kota districts.

H₁: There is a significant difference in help-seeking behavior* among female adolescent student between Jaipur and Kota districts.

***Tests will be conducted for each type of help sought (Therapy or counselling services, Medication prescribed by a doctor, Online resources/self-help) separately.**

1.5. Awareness of Mental Health Support Systems

H₀: There is no significant difference in awareness of mental health support systems among female adolescent student between Jaipur and Kota districts.

H₁: There is a significant difference in awareness of mental health support systems among female adolescent student between Jaipur and Kota districts.

1.6. Perceived Satisfaction with Security Measures

H₀: There is no significant difference in perceived satisfaction with security measures among female adolescent student between Jaipur and Kota districts.

H₁: There is a significant difference in perceived satisfaction with security measures among female adolescent student between Jaipur and Kota districts.

2. Hypotheses Related to Age Differences

H₀: There is no significant difference in mental health indicators* between **younger (15-17 years old) and older (17-19 years old) female adolescents.**

H₁: There is a significant difference in mental health indicators* between **younger (15-17 years old) and older (17-19 years old) female adolescents.**

*** Tests will be conducted for each mental health indicator (Anxiety/Excessive Worry, Loneliness, Panic Attacks, Persistent Sadness or Hopelessness, Suicidal Thoughts) separately.**

3. Hypotheses Related to Place of Stay

H₀: There is no significant difference in mental health indicators between female adolescent students **staying at home** and those **staying away from home**.

H₁: There is a significant difference in mental health indicators between female adolescent students **staying at home** and those **staying away from home**.

Note: Formal hypotheses are not formulated for the 3rd and 4th chapters on Postpartum mental health and Education of differently abled women respectively because the nature of the inquiry will be descriptive and analytical rather than inferential. These chapters are designed to systematically collect data from the stakeholders (their experience and perspectives), document of existing conditions, institutional practices, and policy implementation gaps using descriptive data. Since the variables examined such as availability of services, institutional preparedness, awareness levels, perceived barriers etc. does not require statistical testing or measurement of causal relationships, the application of inferential statistical tests will not be methodologically apt.

1.6. Research Methodology

This research is primarily based on **primary data** collected through structured self-made questionnaires and interviews from respondents in Jaipur and Kota districts by the researcher. The study adopts research design for different chapters.

In addition to primary data, **secondary sources** such as government reports- AISHE Reports (2017-2022), National Education Policy, 2020, World Health Organization's official data, policy documents, official statistics (Census report, etc.), and published research literature were used for conceptual framing, contextual understanding, and interpretation of findings. Secondary sources were not subjected to any kind of analysis like independent statistical analysis or deep study. Instead, they were utilized to understand the empirical findings within the broader policy discourse. Data collected from the field were analyzed using appropriate quantitative

techniques like chi-square test, t-test, etc. and qualitative responses were analyzed separately.

The detailed research methodology comprising the research design, sampling strategy, data collection instruments, data analysis techniques, and ethical considerations has been discussed separately in each chapter, as each chapter (Adolescent Mental health, Postpartum mental health and Education for differently-abled women) adopts a distinct methodological approach.

1.7. Scope of Research

The research objective is to examine women empowerment in Rajasthan with a special focus on health and education of women in the districts of Jaipur and Kota. Empowerment can be achieved through good health and educating women. Health can be divided into two parts i.e., Mental Health and Physical Health. This research studies the mental health of women specifically adolescent mental health (aged between 15 to 19) and postpartum mental health. Whereas in Education, the research dives into education for differently-abled women in Rajasthan; focusing on the declining rate of admission of female differently abled students in the higher education.

This holistic study of two age variation i.e., Adolescence and Postpartum (reproductive age) will help the policy makers to make policies that are carved for specific need of the two age groups. Since, the needs and priorities of both age groups is extremely unique, it demands specific policies for each.

Similarly, the research will also help policy makers to make better policies to limit the drop-out rates of Divyang female and motivate more admissions in the higher education in Rajasthan. It will also aid in the better understanding about the complexities of inclusive education, which will help future policy makers to keep the views of both parents and special educators while making decisions for differently abled students. It is extremely important to keep security in center for female students, especially when they are at an intersection of gender and disability; sometimes even caste, class and region.

IV

1.8. Chapter Scheme

Chapter 1: Introduction

This chapter is divided into four parts. Section I presents an overview of the core idea of the research. Section II discusses the review of literature for each chapter, along with the inferences drawn and the identified research gaps. Section III outlines the research hypotheses, research methodology, and scope of the study. Section IV presents the chapter scheme of the entire thesis.

Chapter 2: Adolescent Mental Health

This chapter is divided into three sections. Section I provides an introduction to adolescent mental health. Section II deals with the research methodology, profile of respondents, and presentation of results. The final section presents the discussion and conclusion of the chapter.

Chapter 3: Postpartum Mental Health

This chapter is divided into three sections. Section I introduces the theme of postpartum mental health. Section II presents the chapter-specific research methodology, including the research questions, study locale and context, study population and sampling strategy, data collection instruments, ethical considerations, and results. Section III comprises the discussion and conclusion.

Chapter 4: Education of Divyang Women

This chapter is divided into three sections. Section I introduces the theme of education of Divyang women. Section II discusses the research methodology and presents the results in detail. The final section offers the discussion and conclusion.

Chapter 5: Conclusion

This chapter synthesizes the key findings of all chapters and presents the overall conclusions of the study.

Chapter 2

Adolescent Mental Health

CHAPTER 2

ADOLESCENT MENTAL HEALTH

The objective of this chapter is to understand Adolescent mental health in the state of Rajasthan; particularly in Jaipur and Kota districts. The chapter is based on data collected from female adolescents aged between 15-19 years of age through self-prepared Questionnaire.

This chapter is divided **into three sections**.

The **First section** provides an **Introduction** to the chapter.

The **Second section** discusses the following in detail:

- **Research Methodology & Profile of Respondents**
 - **Research Design**
 - **Research Locale**
 - **Sampling Strategy**
 - **Data Collection Instruments**
 - **Data Analysis Techniques**
 - **Ethical Considerations**
- **Results**
- **Summary of the key findings**

The **Third section** discusses the following in detail:

- **Discussion**
- **Policy Recommendations**
- **Conclusion**

I

2.1. Introduction

India has the largest adolescent population in the world, 25.3 crores, and every fifth person is between 10 to 19 years (Murthy, 2017). Adolescent of India constitute 17.6% of India's total population. Balamurugan et al. conducted a systematic review titled 'Mental Health Issues Among School Children and Adolescents in India', highlighting the significant prevalence of mental health issues among this demographic. The analysis revealed that depression was the most common issue, followed by social, behavioral, and emotional problems, anxiety, psychological distress, internet technology addiction, stress, social phobia, sexual and emotional abuse, violence, and attention deficit hyperactivity disorder (ADHD). The National Mental Health Survey of 2016 indicated a 7.3% prevalence of mental illness among teenagers, with higher rates in metropolitan areas, where anxiety issues were at 3.6% and depression-related conditions at 0.8%. The review emphasized the need for collective responsibility from parents, educators, and society to nurture children's mental health. However, obstacles such as lack of designated spaces for needy, non-cooperation from school administration, infrequent to none counselor availability, and privacy concerns hinder effective support. Moreover, Mental health issues are still a misunderstood and considered as a taboo in Indian Society. The review reported a wide range of mental health issues, with depression affecting 30.65% of 7,749 school children, and referral rates varying from 12.22% to 51.52%. It was noted that female adolescents exhibited a higher prevalence of depression and anxiety, attributed to poorer social problem-solving skills and negative cognitions. Additionally, hostel-staying students showed a significant association with anxiety disorders (Balamurugan et al., 2024).

In their research and stakeholder analysis, Roy et al. (2019) highlight that India, with the largest adolescent population globally, faces significant mental health challenges, as over half of adult mental disorders begin in adolescence. Common mental health issues identified include stress, anxiety, and depression, often elevated due to pressures such as academic and peer-related. The authors also emphasize a critical lack of clarity regarding mental health as a public health issue, insufficient

information on adolescent challenges, and the necessity for well-defined problems to inform policy development. Furthermore, state governments such as Locale of this study often remain unaware of central directives and fail to secure necessary funding for mental health initiatives, leading to poor implementation of policies. While mental health is recognized in various documents, policies, the depth and detail in addressing the full spectrum of adolescent mental health issues remain inadequate (Roy et al., 2019). Due to a serious gap in the existing issue and implementation of its proper steps and management, the problem continues to exist in adolescence. Adolescent time period is the fittest time of life. If mental health too is taken care of, not just the adolescent's future but the country's future will be safe.

Recent research highlights that depression is the leading cause of disease burden among young individuals, measured in disability adjusted life years (DALYs) (Joshi et al., 2021).

Mental health is a global burden, with one in seven 10-19-year-olds experiencing a mental disorder, accounting for 15% of the global burden of disease. Depression, anxiety, and behavioral disorders are leading causes of illness and disability, and suicide is the third leading cause of death among 15-29-year-olds (World Health Organization, 2024)

Adolescents in India face high suicide rates, with 23.3% of school children and adolescents having psychiatric disorders. Mental health interventions are crucial to address this issue, as suicide is the leading cause of mortality in this population, highlighting the need for comprehensive mental health interventions. (Mehra et al., 2022).

The Supreme Court of India's consistent jurisprudence affirms mental health as a fundamental constitutional right emanating from Article 21, which guarantees the right to life with dignity. The Court emphasized that "mental health is an integral component of the right to life" and defined life not as mere survival but as "a life of dignity, autonomy, and well-being" (Supreme Court, 2025, para. 31). Foundational cases such as *Shatrughan Chauhan v. Union of India* (2014) and *Navtej Singh Johar*

v. Union of India (2018) concretized the recognition of “mental integrity, psychological autonomy, and freedom from degrading treatment as essential facets of human dignity under Article 21” (Supreme Court, 2025, para. 31).

The Supreme Court’s interpretation situates mental health as indispensable to human dignity, necessitating State protection and positive obligations for promotion, prevention, and care. This rights-based expansion challenges reductive biomedical or moralistic views of mental illness, instead framing mental health within a constitutional ethos of justice, autonomy, and respect. The Court also referenced the Mental Healthcare Act, 2017 (MHCA), affirming that “the Act reinforces this constitutional mandate by recognizing every person’s right to access mental healthcare and protection from inhuman or degrading treatment in mental health settings” (Supreme Court, 2025, para. 31).

Of particular importance is Section 115 of MHCA, which “explicitly decriminalizes attempted suicide, acknowledging the need for care and support rather than punishment” (Supreme Court, 2025, para. 31). This transformative legal stance further destigmatizes mental health issues and highlights suicide prevention as a human rights and public health imperative. The jurisprudential framework thus mandates a holistic, rights-based approach wherein institutional structures must not only recognize mental health but actively facilitate its protection, echoing broader constitutional commitments.

II

2.2. Research Methodology & Profile of Respondents

2.2.1. Research Design

The present study adopted a mixed-method research design comprising both quantitative and qualitative approaches. The quantitative dimension was intended to assess trends, relationships, and prevalence of mental health concerns among adolescent girls, while the qualitative component aimed to capture lived experiences, perceptions, and the broader socio-cultural context influencing their mental health.

The study utilized a cross-sectional survey method to gather primary data from adolescent females in Kota and Jaipur, two major educational hubs in Rajasthan. In addition, qualitative insights were supplemented through informal conversations, personal observations, and lived experiences of the respondents, along with one year of first-hand situational observation by the researcher in both cities.

Research Question

How do academic stress, social and emotional support, institutional and administrative support, and safety-related factors influence the mental health and well-being of adolescent girls in Kota and Jaipur districts of Rajasthan?

2.2.2. Research Locale

One of the most compelling reasons for selecting Rajasthan as the focal point of this research is the striking difference in mental health indicators as revealed by the National Mental Health Survey, 2015-16 (Murthy, 2017). For instance, in the category of neurotic and stress-related disorders, the survey reported a nearly **tenfold difference** in prevalence between Assam and Rajasthan. This significant variation raises critical questions about the socio-cultural, economic, and systemic factors unique to Rajasthan that may be contributing to such elevated mental health concerns. A deeper investigation into these localized determinants is essential, and this study seeks to address that very gap in the current body of knowledge (Murthy, 2017).

Moreover, Rajasthan ranks second in the nation with the largest percentage of adolescent population at 22.9% inside the adolescent age range, following Uttar Pradesh. Over 33% of the illness burden and nearly 60% of premature deaths in adults can be linked to behaviors or conditions that originated during the ages of 10 to 19 years (Joshi et al., 2021)

The study was conducted in Kota and Jaipur districts of Rajasthan, which were selected purposively for the following reasons:

- Kota: Known as India's premier coaching hub for competitive examinations, but also associated with frequent reports of adolescent mental health crises, including high suicide rates among students.
- Jaipur: As the capital of Rajasthan, Jaipur represents an urban and educationally vibrant environment, attracting students from across the state as well as other regions of India. In the recent years, Jaipur too has become the centre for coaching hubs attracting students from all over India.

Both cities attract adolescent populations who are studying either at home or away from home, creating a comparable context for analysis. This design also allowed for comparative assessment of place-based influences on the female adolescent mental health.

Primary data collection was conducted over a one-year duration, spanning August 2024 to August 2025, across Jaipur and Kota districts.

2.2.3. Sampling Strategy

The study relied on non-probability sampling methods which are as follows:

- Snowball Sampling: Initial respondents were identified who were distributed the questionnaire personally and then they helped connect the researcher to others within their peer networks.
- Purposive Sampling: Respondents were selected to ensure diversity across categories such as school-going students, aged between 15-19, coaching students, students staying with family, and those living away from home. Respondents were only female.

A total of 560 adolescent females participated in the research:

- Jaipur: 290 respondents
- Kota: 270 respondents

Special care was taken to maintain comparability across the two locations in terms of numbers and respondent categories.

The age group was purposively restricted to 15–19 years, in line with the World Health Organization's definition of adolescence that is "Adolescence is the phase of life between childhood and adulthood, from ages 10 to 19".

Table 2.1: Profile of respondents by age group

Age Group	Jaipur	Kota
15-17	80	75
17-19	210	195

Source: Computed from primary data

Table 2.2: Profile of respondents by the Place of residence

Place of Residence	Jaipur	Kota
At Home	240	90
Away from Home	50	180

Source: Computed from primary data

2.2.4. Data Collection Instruments

The study utilized only primary sources for data collection

Primary Sources

1. Questionnaire (Google Forms)

- A self-designed structured questionnaire comprising approximately 40 questions was used, covering multiple domains including demographics, academic stress, social and emotional support, mental health and well-being, administrative support, security, satisfaction with the existing policies, help seeking behaviour.
- Question types included closed-ended items (mostly multiple-choice, Likert-scale questions) and open-ended questions.
- A few standardized scales/questionnaires (such as WHO mental health tools and other validated instruments) were adapted.
- The self-designed questionnaire was pilot-tested on a small sample of 15 adolescent girls, and necessary modifications were done based on feedback to improve clarity and relevance.
- While most questions yielded usable data, a couple of items were excluded from final analysis due to unsatisfactory or unreliable responses, ensuring that only high-quality and meaningful data were considered.
- The data was further calculated and analyzed using Microsoft Excel. Tests were applied using Microsoft Excel.

2. Qualitative Inputs

- Respondents shared personal experiences and perspectives via open-ended questions and informal conversations, enhancing the quantitative data.

3. Field Observation

- The researcher also conducted non-intrusive observation over one year each in Jaipur and Kota districts, focusing on students' behavior, especially female students around educational institutions for contextual understanding.

2.2.5. Variables in the study

1. Independent Variables

- District (Jaipur, Kota)
- Age group (15–17 years, 17–19 years)
- Residential status (At home, away from home)

2. Dependent Variables

- Indicators of mental health conditions (stress, anxiety, depression tendencies, emotional resilience, peer influence, and coping mechanisms)

2.2.6. Data Analysis Techniques

The collected data was analyzed using Microsoft Excel. The following procedures were applied:

1) Quantitative Analysis:

- a) Descriptive statistics: frequencies, percentages, mean, and standard deviation.
- b) Inferential statistics:
 - i) *Chi-square tests* for examining categorical associations (e.g., between city, age group, place of residence and stress prevalence);
 - ii) *t-test* to compare the mean stress score;
 - iii) Standard deviation was used to measure variation in responses.

2) Qualitative Analysis:

- a) Narrative experiences of respondents were examined and discussed in the Discussion section.

3) Comparative Analysis:

- a) Data was compared between Jaipur and Kota, age groups (15–17 vs. 17–19 years), living arrangements (home vs. away), help-seeking behaviour among various cities, and age groups.

2.2.7. Ethical Considerations

Verbal consent was obtained from the parents of adolescents during home visits, after explaining them the purpose of the study. In addition, consent was obtained directly from the adolescent respondents through the Google Form itself. The form included a clear introductory paragraph explaining the purpose of the study, confidentiality assurances, anonymity at all time (from beginning till the end of the study), voluntariness of participation, and the right to withdraw at any time. Respondents were required to actively consent by selecting an “I consent” option before proceeding with the questionnaire. This procedure ensured informed, voluntary participation and respected the autonomy of adolescent respondents. To protect privacy and confidentiality, no personal identifying information such as names or residential addresses was collected. Only non-identifiable demographic details like age group (15–17 or 17–19 years) and living arrangement (at home or away from home) were recorded to use for the comparative analysis. Respondents were free to withdraw at any stage during the data collection process.

2.3. Results

The Objectives, Hypothesis and the Research Gap has been discussed in the Chapter 1 (Introduction).

2.3.1. District-Wise Comparison (Jaipur versus Kota)

2.3.1.1. Frequency of Overwhelm Among Adolescents

H₀: There is no significant difference in the frequency of overwhelm among female adolescent students between Jaipur and Kota districts.

H₁: There is a significant difference in the frequency of overwhelm among female adolescent students between Jaipur and Kota districts.

To understand the stress frequency, students were asked how often they feel overwhelmed, with five response options ranging from ‘Almost every day’ to ‘Never’.

Table 2.3: District-wise Frequency of Feeling Overwhelmed; Chi-Square test					
Frequency Category	Jaipur (n=290)	Kota (n=270)	Total (N=560)	Chi-Square	p-value
Almost Every Day	65 (22.4%)	30 (11.1%)	95 (17.0%)	15.08	0.0045
Almost Every Week	80 (27.6%)	90 (33.3%)	170 (30.4%)		
Almost Every Month	75 (25.9%)	85 (31.5%)	160 (28.6%)		
Very Rarely (Once in 6 Months)	60 (20.7%)	60 (22.2%)	120 (21.4%)		
Never	10 (3.4%)	5 (1.9%)	15 (2.7%)		

Source: Computed from primary data, p-value 0.05 is significant

Table 2.3. shows that more students in Jaipur feel overwhelmed almost daily (22.4%), while students in Kota show a higher tendency for weekly or monthly overwhelm. The research indicates that more than 97% of students reported experiencing some level of overwhelm, while merely 2.7% claimed they never feel overwhelmed. This suggests that stress is concerning at an alarming level among adolescents in the sample.

A Chi-square test of independence was used to test if the difference in response patterns between cities was statistically significant. This test examined if the two categorical variables that is Districts (Jaipur and Kota) and the Frequency of Overwhelm are associated

Since the p-value is below 0.05, **the null hypothesis stands rejected**. Hence, there is a significant difference between city and how frequently students feel overwhelmed.

2.3.1.2. Academic Stress Levels

H₀: There is no significant difference in the academic stress levels among female adolescent students between Jaipur and Kota districts.

H₁: There is a significant difference in the academic stress levels among female adolescent students between Jaipur and Kota districts.

Table 2.4: t- test of District-wise comparison of Academic Stress among

Adolescent Girls					
District	Sample Size (N)	Mean Stress Score	Standard Deviation (SD)	t-test (558)	p-value
Jaipur	290	3.50	0.97	5.07	<0.001
Kota	270	3.09	0.93		

Note: Scores are based on a self-reported 5-point Likert scale, where 1 = least stressed and 5 = most stressed.

A comparative study to assess **academic stress** among adolescent girls in the Jaipur and Kota districts on a **5-point Likert scale (1 = least stressed, 5 = most stressed)** showed mean stress level in **Jaipur** as **3.50 (SD = 0.97)**, compared to **3.09 (SD = 0.93)** in Kota. An independent samples t-test show that this difference is statistically significant, $t(558) = 5.07, p < 0.001$.

Since the p-value is < 0.05 , thus, **the null hypothesis stands rejected**. These findings indicate that adolescents in the Jaipur district report significantly higher academic stress compared to their counterparts in Kota.

2.3.1.3. Mental health issues/symptoms in female Adolescents

H₀: There is no significant difference in mental health indicators* among female adolescent student between Jaipur and Kota districts.

H₁: There is a significant difference in mental health indicators* among female adolescent student between Jaipur and Kota districts.

***Tests will be conducted for each mental health indicator (Anxiety/Excessive Worry, Loneliness, Panic Attacks, Persistent Sadness or Hopelessness, Suicidal Thoughts) separately.**

A comparison of Mental health symptoms/indicators was done between Jaipur and Kota districts. The symptoms include Anxiety or Excessive worry, Loneliness, Panic attacks, Persistent sadness or hopelessness and suicidal thoughts. Every single symptom was compared against each district to get a keen insight.

Table 2.5: Comparison of Mental Health Issues in Jaipur versus Kota Districts; chi-test

<i>(Respondents can choose more than one option)</i>				
Mental Health Symptom	Jaipur (n, %)	Kota (n, %)	Statistical Significance (p-value)	Higher in
Anxiety or excessive worry	190 (66%)	150 (56%)	Statistically significant (p = 0.020)	Jaipur
Loneliness	145 (50%)	95 (35%)	Highly significant (p = 0.0006)	Jaipur
Panic attacks	60 (21%)	50 (19%)	Not significant (p = 0.5894)	Jaipur
Persistent sadness/hopelessness	155 (53%)	85 (31%)	Highly significant (p < 0.001)	Jaipur
Suicidal thoughts	50 (17%)	20 (7%)	Highly significant (p = 0.0007)	Jaipur
None of the above	55 (19%)	65 (24%)	Not significant (p = 0.171)	Kota

Source: Computed from primary data

Table 2.5 clearly indicates that the majority of reported mental health issues/symptoms are among adolescent girls in Jaipur as compared to Kota, with most differences attaining statistical significance. Anxiety or excessive worry is the predominant symptom in both the districts; however, it was reported substantially more in Jaipur (66%) compared to Kota (56%) ($p = 0.020$). Persistent loneliness (50% in Jaipur vs. 35% in Kota) and persistent sadness or hopelessness (53% in Jaipur vs. 31% in Kota) exhibit considerable disparities and are statistically significant ($p < 0.001$ for sadness; $p = 0.0006$ for loneliness), highlighting a greater mental health crisis among respondents from Jaipur. Instances of suicidal thoughts were more than twice as prevalent in Jaipur (17%) compared to Kota (7%), with a statistically significant difference ($p = 0.0007$), indicating a critical mental health crisis for Jaipur's adolescent girls.

Panic attacks exhibited no variation between the two cities (21% vs. 19%, not significant), but a marginally greater percentage in Kota opted for “none of the

above” (24% vs. 19%, not significant), indicating a slightly reduced overall symptom reporting in Kota.

Since the p-value is below 0.05 in the following cases-

- Anxiety or excessive worry ($p = 0.020$); Jaipur is higher
- Loneliness ($p = 0.0006$); Jaipur is higher
- Persistent sadness or hopelessness ($p < 0.001$); Jaipur is higher
- Suicidal thoughts ($p = 0.0007$); Jaipur is higher.

The Null hypothesis stands rejected for these cases.

Hence, this indicates a statistically significant difference between Kota and Jaipur for the above four stated mental health symptoms.

The following table 2.6 analyses the **Mean of average stress among all the respondents across both districts and age groups**

Table 2.6: Mean of average stress among all the respondents across both districts and age groups <i>(Respondents can choose more than one symptom)</i>		
Symptoms	Mean Academic Stress (1–5)	No. of Respondents
Anxiety or excessive worry	3.56	340
Loneliness	3.60	240
None of the above	2.58	120
Panic attacks	3.82	110
Persistent sadness or hopelessness	3.65	240
Suicidal thoughts	4.14	70

Source: Computed from primary data

Table 2.6. shows that students reporting symptoms like panic attacks, persistent sadness, loneliness, anxiety, or especially suicidal thoughts experience substantially higher average academic stress (means 3.56–4.14 on a 5-point scale) compared to those with no symptoms (mean 2.58).

The mean perceived academic stress levels were higher among respondents reporting one or more than **one symptom (3.66)** compared to those reporting **no symptoms (2.58)**.

Further, students reporting the symptom of **Suicidal thoughts had the highest mean stress score ($M = 4.14$)** indicating that more severe psychological symptoms are strongly linked with elevated academic stress, followed by panic attacks at ($M = 3.82$), Persistent sadness or hopelessness at ($M = 3.65$), Loneliness at ($M = 3.60$), and Anxiety or excessive worry ($M = 3.56$). While respondents reporting **no symptoms had the lowest mean stress score at 2.58**.

As individuals could report multiple symptoms, this ordering reflects patterns of association rather than statistically tested differences. So, although these findings are descriptive in nature, the observed symptom-wise ordering of mean academic stress levels offers useful starting point for identifying symptoms that appear to be associated with higher perceived stress.

Table 2.7: District wise mean stress per symptom					
Mental Health Symptom	Avg. Stress (Jaipur)	Count (Jaipur)	Avg. Stress (Kota)	Count (Kota)	Higher Stress in
Anxiety or excessive worry	3.68	190	3.40	150	Jaipur
Loneliness	3.90	145	3.16	95	Jaipur
None of the above	2.73	55	2.46	65	low overall
Panic attacks	4.00	60	3.60	50	Jaipur
Persistent sadness or hopelessness	3.90	155	3.18	85	Jaipur
Suicidal thoughts	4.30	50	3.75	20	Jaipur

All scores are on a 1–5 scale (1 = least stressed, 5 = most stressed).

Students were given option to select multiple symptoms, but their stress score was recorded only once.

Each mental health symptom was treated as an independent indicator. Average academic stress levels were compared between respondents from Jaipur and Kota who selected each symptom. Although students could select multiple symptoms, their academic stress was self-reported as a single value, allowing comparison symptom-wise without violating independence of stress scores. Table 2.6 presents

the mean level of academic stress indicated by female adolescents expressing particular mental health symptoms, integrating data from both districts and age demographics.

This was not a comparative analysis among districts, but a comprehensive assessment of stress levels over complete sample. Students experiencing suicidal thoughts showed a disturbing mean academic stress intensity (mean = 4.14), followed by those with panic attacks (mean = 3.82) and those with persistent sadness or hopelessness (mean = 3.65). These scores are notable in comparison to feelings like anxiety or loneliness, which, although elevated, had marginally lower means (3.56 and 3.60, respectively). Respondents without mental health symptoms exhibited a much lower average stress score of 2.58, underscoring the correlation between mental health problems and academic stress.

2.3.1.4. Help-seeking Behavior

The following section analyzes the help-seeking behavior among female adolescent in both the districts i.e., Jaipur and Kota. Firstly, the analysis is among students who are in mental health crisis and sought help and students who are in mental health crisis but did not seek help. Then understanding the statistical difference among help seeking behavior among adolescents.

Among 560 total respondents, 440 reported to have experienced one or more than one mental health issues. While 150 female adolescent (75 from Jaipur, 75 from Kota) sought help, 290 students did not seek any help.

Table 2.8: Help-seeking behavior among Jaipur and Kota districts			
District	Sought Help	Did Not Seek Help	Total
Jaipur	75	160	235
Kota	75	130	205
Total	150	290	440

Source: Computed from primary data

34% of students sought help (Jaipur and Kota combined (150 out of 440). 66% of students did not seek help (Jaipur and Kota combined (290 out of 440). This is further divided into two-

- **Students who sought help**
- **Students who did not seek help**

The following section analyzes the trend among **students who sought help**.

Hypotheses for this section

H₀: There is no significant difference in the type of help sought* among female adolescent student between Jaipur and Kota districts.

H₁: There is a significant difference in the type of help sought* among female adolescent student between Jaipur and Kota districts.

***Tests will be conducted for each type of help sought (Therapy or counselling services, Medication prescribed by a doctor, Online resources/self-help) separately.**

Table 2.9: Analysis of trend where students sought help (Respondents can choose more than one option)		
Type of Help	Kota (n=75 students)	Jaipur (n=75 students)
Therapy or counselling services	45 (60%)	20 (27%)
Medication prescribed by a doctor	25 (33%)	15 (20%)
Online resources/self-help	20 (27%)	20 (27%)
Other resources	25 (33%)	30 (40%)

Source: Computed from primary data

Table 2.10: Chi-Square Test Results Comparing Types of Help Sought by Students in Kota and Jaipur			
Type of Help	Chi²	p-value	Statistical Significance
Therapy or counselling services	15.64	0.0001	Highly significant
Medication prescribed by a doctor	2.76	0.0966	Not significant

Online resources/self-help	0.00	1.0000	Not significant
Other resources	0.46	0.4979	Not significant

Source: Computed from primary data

As depicted in Table 2.9. and table 2.10. that a higher proportion of students in Kota (60%) reported seeking therapy or counselling services compared to Jaipur (27%) although the issue is severe in Jaipur (Table 2.3, Table 2.4, Table 2.5).

The chi-square test confirmed this difference to be statistically significant ($\chi^2 = 15.64$, $p = 0.0001$).

For medication, use was somewhat higher among Kota students (33%) relative to Jaipur students (20%), though this difference was not statistically significant ($\chi^2 = 2.76$, $p = 0.0966$). Use of online or self-help resources was identical across the two districts (27% each; $\chi^2 = 0.00$, $p = 1.000$) and reliance on other resources showed a small variation (33% in Kota vs. 40% in Jaipur), but again without statistical significance ($\chi^2 = 0.46$, $p = 0.4979$).

The following section analyzes the trend amongst **students who did not seek help**.

Hypothesis for this section-

H₀: There is no significant difference in the reason of not seeking help* among female adolescent student between Jaipur and Kota districts.

H₁: There is a significant difference in the reason of not seeking help* among female adolescent student between Jaipur and Kota districts.

***Tests will be conducted for each type of help sought (Belief that issue will resolve on its own, financial barriers, Lack of access to resources, Stigma or shame, Others) separately.**

The following table discusses the number of female adolescent students who did not seek help and what were the probable reasons for the same.

Table 2.11: Analysis of trend where students DID NOT seek help (Jaipur and Kota) <i>(Respondents can choose more than one option.)</i>		
Reason	Kota (n = 130 students)	Jaipur (n = 160 students)
Belief that issue will resolve on its own	95 (73%)	95 (59%)

Financial barriers	10 (8%)	25 (16%)
Lack of access to resources	10 (8%)	40 (25%)
Stigma or shame	15 (12%)	20 (13%)
Others	40 (31%)	20 (13%)

Source: Computed from primary data

Table 2.12: Chi-Square Test Results for Differences in Reasons for Not Seeking Help Between Jaipur and Kota Districts			
Reason	Chi²	p-value	Statistical Significance
Belief issue will resolve on its own	5.37	0.0205	Moderately significant
Financial barriers	3.54	0.0600	Not significant
Lack of access to resources	13.87	0.0002	Highly significant
Stigma or shame	0.00	0.9452	Not significant
Others	13.50	0.0002	Highly significant

Table 2.11 shows that the most common reason for not seeking help among female adolescents in both districts was **the belief that the issue would resolve on its own**. It was reported by 73% of students in Kota and 59% in Jaipur (Table 2.11). Financial barriers and lack of access to resources were reported more frequently in Jaipur (16% and 25%, respectively) compared to Kota (8% each) (Table 2.11).

Chi-square analysis in Table 2.12 indicates that differences between Kota and Jaipur were **statistically significant** for the beliefs that the issue would resolve on its own ($\chi^2 = 5.37$, $p = 0.0205$), lack of access to resources ($\chi^2 = 13.87$, $p = 0.0002$), and other reasons ($\chi^2 = 13.50$, $p = 0.0002$). However, financial barriers and stigma or shame did not differ significantly between the two cities.

Additionally, a space was provided to the respondents for open ended response and 'lack of time' was noted as a significant barrier by 38% of Jaipur students.

Since the p-value for the female students is less than 0.05 in the following cases-

Therapy or counselling services (0.0001)- Table 2.10

Belief issue will resolve on its own (0.0205)- Table 2.12

Lack of access to resources (0.0002)- Table 2.12;

Hence, the **Null hypothesis stands rejected for the above three cases.**

2.3.1.5. Awareness of mental health support systems

H₀: There is no significant difference in awareness of mental health support systems among female adolescent student between Jaipur and Kota districts.

H₁: There is a significant difference in awareness of mental health support systems among female adolescent student between Jaipur and Kota districts.

Following section discusses the perceived adequacy of Institutional, Local and State by the female adolescents of Jaipur and Kota Districts

Table 2.13: City wise satisfaction with Institution's Mental health support system				
City	Neutral	Not Satisfied	Somewhat Satisfied	Very Satisfied
Jaipur (N=290)	130	25	75	60
Kota (N=270)	120	35	75	40

Source: Computed from primary data

As shown in Table 2.13, in both locations, the 'Neutral' option was predominant (Jaipur: 44.8%, Kota: 44.4%). Kota exhibited a marginally elevated rate of 'Not Satisfied' response (13.0%) in comparison to Jaipur (8.6%). 'Very Satisfied' was marginally greater in Jaipur (20.7%) as compared to Kota (14.8%).

Following Table 2.14 discusses the city-wise awareness of mental health schemes by the State Government of Rajasthan

Table 2.14: City-wise Awareness of Mental Health Schemes (State Government) for Female Students in Rajasthan				
Row Labels	No	Yes	Chi²	p-value
Jaipur (N=290)	230 (79.3%)	60 (20.7%)	35.35	<0.001
Kota (N=270)	260 (96.3%)	10 (3.7%)		

Source: Computed from primary data

Table 2.14 shows that a higher proportion of female students in Jaipur (20.7%) reported awareness of state government mental health schemes compared to Kota (3.7%). Conversely, 79.3% of respondents in Jaipur and 96.3% in Kota reported no awareness of such schemes. The chi-square test revealed a **significant difference between city and awareness of mental health schemes** ($\chi^2 = 35.35$, $df = 1$, $p < 0.001$).

Hence, **Null hypothesis stands rejected.**

This suggests that there is a significant difference between awareness of mental health schemes female among adolescent students in two districts.

2.3.1.6. Perceived satisfaction with security measures

H₀: There is no significant difference in perceived satisfaction with security measures among female adolescent student between Jaipur and Kota districts.

H₁: There is a significant difference in perceived satisfaction with security measures among female adolescent student between Jaipur and Kota districts

Security is a very important factor for female, not just for their physical safety but also mental health. Following table discusses the perceived adequacy of security provided by their institution.

Table 2.15: Perceived Adequacy of Institutional Security for Female Students					
Districts	Maybe	No	Yes	Chi²	p-value
Jaipur	95	35	160	2.10	>0.05
Kota	80	25	165		

Source: Computed from primary data

Table 2.15 shows a majority of female students in Jaipur (55.2%) and Kota (61.1%) regarded institutional security as sufficient. Approximately one-third of participants in both areas responded with 'Maybe' (32.8% in Jaipur, 29.6% in Kota). The percentage indicating insufficiency declined, with 12.1% in Jaipur and 9.3% in Kota.

Since the p-value is more than 0.05, **it fails to reject the null hypothesis** which indicates that there is no significant difference in perceived adequacy among two districts ($\chi^2 \approx 2.10$, $df = 2$, $p > 0.05$).

2.3.1.7. Feeling of Security while commuting

Out of a total of 560 respondents (290 from Jaipur and 270 from Kota), **240 in Jaipur (82.8%)** and **210 in Kota (77.8%)** reported feeling safe on their everyday commutes to and from their education institutions

2.3.2. Age-groups' comparison (Younger and Older Adolescents)

H₀: There is no significant difference in mental health indicators* between **younger (15-17 years old) and older (17-19 years old) female adolescents.**

H₁: There is a significant difference in mental health indicators* between **younger (15-17 years old) and older (17-19 years old) female adolescents.**

*** Tests will be conducted for each mental health indicator (Anxiety/Excessive Worry, Loneliness, Panic Attacks, Persistent Sadness or Hopelessness, Suicidal Thoughts) separately.**

Following table discusses the Mental health indicators such as anxiety, hopelessness, etc. by age groups i.e., age group between 15-17 and 17-19 in female adolescents of Jaipur and Kota districts.

Table 2.16: Psychological Symptoms by Age Group (Respondents can choose more than one option)		
Mental Health Indicators	Age 15-17	Age 17-19
Anxiety or Excessive Worry	85 (55%)	255 (63%)
Loneliness	45 (29%)	195 (48%)
Panic Attacks	25 (16%)	85 (21%)
Persistent Sadness or Hopelessness	45 (29%)	195 (48%)
Suicidal Thoughts	25 (16%)	45 (11%)
None of the Above	45 (29%)	75 (19%)

Source: Computed from primary data

Table 2.17: Chi-Square Test of Independence for Symptom Frequency by Age Group			
Symptom	χ^2 Value	p-Value	Significant?
Anxiety or Excessive Worry	2.77	0.096	No
Loneliness	15.95	<0.001	Yes

Panic Attacks	1.38	0.240	No
Persistent Sadness or Hopelessness	15.95	<0.001	Yes
Suicidal Thoughts	2.14	0.143	No
None of the Above	6.75	0.009	Yes

Source: Computed from primary data

The results of Table 2.16 and table 2.17 is discussed in detail below.

1. Anxiety or Excessive Worry

Anxiety and excessive worry are the most common symptoms among female adolescents of both age groups. Notably, anxiety appears to increase with age. In the data representing 15–17 age group, 55% (n=85) reported experiencing anxiety, which increased to 63% (n=255) among 17–19-year-olds; however, this change **was not statistically significant** ($\chi^2 = 2.77$, $p = 0.096$). Although the difference does not achieve statistical significance, the observed upward trend is noteworthy. Since the p value is equal to 0.096, it **fails to reject the Null Hypothesis**.

2. Loneliness

Loneliness is much higher among older adolescents. Among students aged 15–17, 29% (n=45) experienced loneliness, which rose sharply to 48% (n=195) in the 17–19 age group. This difference is **statistically significant** ($\chi^2 = 15.95$, $p < .001$) indicating that the fear of loneliness is profound in the older adolescent as compared to the younger ones.

Hence, **it rejects the Null Hypothesis**. Therefore, there is a significant difference between the age groups of female adolescents (aged 15-17 and 17 to 19) and mental health indicator i.e., Loneliness.

3. Panic Attacks

Again, Panic attacks are more common in the older age group. While 16% (n=25) of adolescents aged 15–17 reported panic attack. It was 21% (n=85) among 17–19-year-olds. However, this change **is not statistically significant** ($\chi^2 = 1.38$, $p = 0.240$).

Hence, it **fails to reject the Null Hypothesis**.

4. Persistent Sadness or Hopelessness

Older adolescents reported higher rates of persistent sadness. 29% (n=45) of 15–17-year-olds reported such feelings, which rises sharply to 48% (n=195) in the older group.

This difference was **statistically significant** ($\chi^2 = 15.95$, $p < 0.001$) indicating that there is a feeling Hopelessness as adolescent slowly move towards adulthood and persistent sadness as compared to the younger ones. Since the p value is less than 0.001, **Null Hypothesis stands rejected**.

4. Suicidal Thoughts

Unlike other symptoms which is more concerning in the older adolescent, suicidal thoughts is higher among younger adolescent. However, the difference is not statistically significant ($\chi^2 = 2.14$, $p = 0.143$). Hence, **it fails to reject the Null Hypothesis**.

6. None of the Above

While 29% of younger adolescents reported no symptoms, only 19% of older adolescents did a significant difference was observed in the selection of 'None of the Above' across age groups. This difference was statistically significant ($\chi^2 = 6.75$, $p = 0.009$). Hence the **Null Hypothesis stands rejected**.

2.3.3. Residence-based Academic Pressure (At Home vs. Away from home)

H₀: There is no significant difference in mental health indicators* between female adolescent students **staying at home and those staying away from home**.

H₁: There is a significant difference in mental health indicators* between female adolescent students **staying at home and those staying away from home**.

*** Tests will be conducted for each mental health indicator (Anxiety/Excessive Worry, Loneliness, Panic Attacks, Persistent Sadness or Hopelessness, Suicidal Thoughts) separately.**

This section analyzes mental health symptoms based on responses from adolescent females living at home or in alternative accommodations such as Hostel, PG, etc.

Each symptom was regarded as an independent binary variable (present or absent), and the percentage for each symptom was calculated using the total number of students in that living arrangement group as the (n = 330 for those residing at home, n = 230 for those living away from home). For example, if 215 girls residing at home experienced anxiety, the prevalence is computed as $(215 \div 330) \times 100 = 65.2\%$. These percentages indicate the frequency of specific symptoms within each group. Chi-square tests of independence were conducted for each symptom to determine if there was a statistically significant difference between the two groups.

Table 2.18: Mental health symptoms among female adolescent based on Residence (Jaipur and Kota combined) <i>(Respondents can mark more than one symptom)</i>				
Symptom	At Home (n = 330)	% of Group	Away from Home (n = 230)	% of Group
Anxiety or excessive worry	215	65.2%	125	54.3%
Loneliness	140	42.4%	100	43.5%
None of the above	70	21.2%	50	21.7%
Panic attacks	60	18.2%	50	21.7%
Persistent sadness or hopelessness	160	48.5%	80	34.8%
Suicidal thoughts	50	15.2%	20	8.7%

Source: Computed from primary data. The percentage is based on group totals.

The above table illustrates an interesting shift from the widespread societal belief that students feel the safest at home. On the contrary, female adolescent staying at home reported more mental health symptoms as compared to the students staying away from home (Hostel, PG, etc.). Students staying at home reported higher

percentage of Anxiety or excessive worry, persistent sadness or hopelessness and suicidal thoughts as compared to their counter parts whereas Loneliness was more prevalent among students staying away from home, although marginally (42.4% vs. 43.5%). Students who did not report any symptom were similar in both the situations that is ~ 21%.

The following Table discusses whether there is any significant difference between each of these symptoms against the Place of Residence using Chi-test.

Table 2.19: Chi square test to test the symptoms of mental health issues in female adolescent based on residence						
Symptom	At Home (n = 330)	Away from Home (n = 230)	χ^2 Value	p- Value	Significant?	Group More Affected
Persistent sadness or hopelessness	160 (48.5%)	80 (34.8%)	9.84	0.002	Yes	At Home
Anxiety or excessive worry	215 (65.2%)	125 (54.3%)	6.19	0.013	Yes	At Home
Suicidal thoughts	50 (15.2%)	20 (8.7%)	4.59	0.032	Yes	At Home
Panic attacks	60 (18.2%)	50 (21.7%)	0.87	0.350	No	—
Loneliness	140 (42.4%)	100 (43.5%)	0.03	0.872	No	-
None of the above	70 (21.2%)	50 (21.7%)	0.00	0.964	No	-

Source: Computed from primary data.

In Table 2.19., statistically significant differences were noted for persistent sadness or hopelessness (48.5% vs. 34.8%, $p = 0.002$), anxiety or excessive worry (65.2% vs. 54.3%, $p = 0.013$), and thoughts of suicide (15.2% vs. 8.7%, $p = 0.032$), with the at-home sample demonstrating a higher rate in each instance. Hence the **Null Hypothesis stands rejected**.

In contrast, the rates of loneliness (42.4% vs. 43.5%) and panic attacks (18.2% vs. 21.7%) were nearly same in the two residential groups, with no statistically significant differences observed.

Therefore, it fails to reject the Null Hypothesis.

2.4. Summary of the Key Findings

- More than **97%** of female adolescent students reported experiencing some **level of overwhelm**, while merely **2.7%** never felt overwhelmed.
- Adolescents in the **Jaipur** district report **significantly higher academic stress** compared to their counterparts in Kota ($p < 0.001$).
- **66%** of adolescents in the **Jaipur district** reported **anxiety or excessive worry** in comparison to **56% in Kota** ($p = 0.020$).
- **50%** of adolescents in the **Jaipur district** reported **Loneliness** in comparison to **35% in Kota** ($p = 0.0006$).
- **53%** of adolescents in the **Jaipur district** reported **Persistent sadness/hopelessness** in comparison to **31% in Kota** ($p < 0.001$).
- **17%** of adolescents in the **Jaipur district** reported **suicidal thoughts** in comparison to **7% in Kota** ($p = 0.0007$).
- Students reporting the symptom of **Suicidal thoughts had the highest mean stress score ($M = 4.14$)** indicating that more severe psychological symptoms are strongly linked with elevated academic stress, followed by panic attacks at ($M = 3.82$), Persistent sadness or hopelessness at ($M = 3.65$), Loneliness at ($M = 3.60$), and Anxiety or excessive worry ($M = 3.56$). While respondents reporting **no symptoms had the lowest mean stress score at 2.58**.
- In District wise mean score, **Jaipur showed higher mean score in All the mental health symptoms** which includes **anxiety or excessive worry (3.68)**, **Loneliness (3.90)**, **Panic attacks (4.00)**, **Persistent sadness (3.90)** and **suicidal thoughts (4.30)**.
- **440 out of 560 students** (Jaipur and Kota combined) experienced one or more than one mental health issue.
- Only **150 students out of 440 (34%)** students **sought** any kind of **help**.
- **290 out of 560 (66%)** students **did not seek** any kind of **help**.
- **Therapy or counseling** was the **most sought-after help** by students of **Kota (60%)** in comparison to **Jaipur** where **only 27%** of students took therapy. The difference is highly significant statistically ($p = 0.0001$).

- 73% of students in **Kota** and 59% of students in **Jaipur** did not seek help with the **Belief that issue will resolve on its own**.
- 25% of students reported **lack of resources** to seek help in **Jaipur**.
- 96.3% students in **Kota** and 79.3% students in **Jaipur** are **unaware of any Mental health schemes by the State Government**.
- **Older adolescents (aged between 17-19)** experience **more anxiety (63% vs 55%), loneliness (48% vs 29%), panic attacks (21% vs 16%), persistent sadness or hopelessness (48% vs 29%) as compared** to their younger counterparts **aged between 15-17 years of age**.
- **Suicidal thoughts** are experienced more by the **younger adolescent (16%)** in comparison to older adolescents **(11%)**.
- Students **staying at home** reported **more persistent sadness or hopelessness (48.5% vs. 34.8%), anxiety or excessive worry (65.2% vs. 54.3%) and suicidal thoughts (15.2% vs. 8.7%)** in comparison to those **staying away from home**.
- Out of a total of 560 respondents (290 from Jaipur and 270 from Kota), **240 in Jaipur (82.8%)** and **210 in Kota (77.8%)** reported feeling safe on their everyday commutes to and from their education institutions.

III

2.5. Discussion

This chapter discusses the adolescent mental health in the state of Rajasthan. It is specific to only one gender that is Female because female suffer from Depression more than men (Dandona et al., 2023; World Health Organization, 2025) . This gender-specific focus underlines an urgent need for targeted mental health interventions for female coaching students in India's major educational hubs. While the National Crime Records Bureau and IC3 Institute provide gender-aggregated student suicide data showing a 7% increase in female student suicides from 2021 to 2022 (IC3 Institute, 2024), city-level official data remains unavailable.

The research focuses on two districts of Rajasthan that is Jaipur, the state Capital and Kota, the coaching hub. A total of 560 respondents from both the district

participated in the study. The data was collected via Google forms and personal meetings. The sample was collected through Purposive sampling, Convenient sampling and Snowball Sampling. The collected data was further analyzed in detail between the two districts, two age groups and place of residence. Each of these comparisons were done to understand the frequency of overwhelm by the female adolescents and its impact of mental health. Various mental health indicators were used such as anxiety, persistent sadness, panic attacks, etc. Mental health issues were compared further between two age groups i.e., 15-17 and 17-19. Any responses which did not fit into the necessary age group were omitted. Mental health issues were further compared between the place of residence. Statistical tests were done wherever it was necessary.

Some of the results that came out of the thorough research and its testing are consistent with previous findings. Whereas others contradict the precious results. There are certain results in this research which has not been researched yet, hence is new to this field of literature. All the findings are discussed in detail in this section. In the District wise comparison between Jaipur and the Kota districts, the frequency of overwhelm (to have such a strong emotional effect that you struggle to react (Oxford Dictionary)), female adolescents residing in Jaipur showed more frequency of overwhelm in comparison to students residing in Kota. Female adolescent in Jaipur felt overwhelmed almost every day whereas students in Kota felt overwhelmed either weekly or monthly (Table 2.3). This was consistent with the result (Table 2.4) where girls in Jaipur report higher level of stress as compared to students in Kota. When the mental health symptoms were dealt in detail, it confirmed the above findings as among all the studied mental health indicators such as Anxiety or excessive worry, Loneliness, panic attacks, persistent sadness and suicidal thoughts, four of the symptoms (Anxiety or excessive worry, loneliness, persistent sadness, suicidal thoughts) were not only higher in Jaipur but also statistically significant difference was found (Table 2.5). Overall, the mean stress per symptom was highest in Jaipur (Table 2.7). All the above findings are consistent with the findings of Shergill & Rathore Hooja, 2025. They found that perceived familial gender discrimination significantly predicts feelings of entrapment and poor

mental health outcomes, accounting for 42.6% of the variance in Jaipur girls. The study perceives that possible reason for this result could be attributed to the familial pressure to perform better in tests, dual burden of gender, and family issues unrelated to academia indirectly affecting the students' stress level. Their findings highlight that gender discrimination by parents and family members is associated with trauma-related and stress-related psychological distress, reinforcing the notion that domestic environments can be sites of significant psychological strain for young women (Shergill & Rathore Hooja, 2025).

Narratives during the field study by female participants also indicate the reason for higher level of stress,

“I handle both college and coaching together. After college, I come back and immediately rush back to coaching. Piles of reading pile up if I get sick for one day or procrastinate. I cannot afford to take a single day break. This will be my 3rd attempt for the National level competitive exam that I am preparing for. When I take a break, I don’t feel relaxed but worry what if fail... how will my future look like... What will be the point if I am not someone, I always aspired to be...”

(Female student, 19, Jaipur, Field Notes)

Narratives like this highlight the reality of strain, stress and haste in a competitive atmosphere in metropolitan educational hubs especially for female gender as she struggles with academic stress and societal expectations combined, where working hard and managing everything remains no guarantee of academic success. Such high stress levels begin at an early age.

Contrary to widespread news positioning Kota as Country's most psychologically distressing educational environment (Kar & Arafat, 2023; Saharan, 2023; Shekhawat et al., 2023), this study reveals that female students in Jaipur consistently report significantly higher rates of mental health distress in comparison to Kota. Yet, it is

imperative to note that although the present study indicates a higher level of stress in female adolescents of Jaipur, it does not diminish the mental health crisis of Kota. Media as well as previous researches have shown multiple evidences of mental health crisis in Kota. Studies such as Souvik Pal's review of adolescent mental health in Kota - India's coaching capital - exposes an acute crisis with systemic dimensions. Kota recorded 32 student suicides in 2023 alone (includes both the genders), which is indicative of such extreme socio-educational stressors (Pal, 2025). Pal identifies "parental anticipation, intense academic pressure, social isolation, and insufficient mental health support" as critical contributors to suicidal thoughts, with "44.45% of coaching aspirants experiencing high academic stress" (Pal, 2025, Purpose of Review). There has always been a considerable media and policy attention on Kota's student suicide crisis - reporting 127 cases over the past decade (includes both genders), including 16 in 2024 - rightly underscores a grave issue in Kota. Yet, the elevated levels of academic stress, particularly during examination periods, suggest a wider mental health challenge that exceeds the prominently reported incidents in Kota. (V. Gupta et al., 2025; Niazi, 2025). One such narrative from the field note is as follows,

"While preparing for competitive exams, especially as the dates approach, I interact very little with my friends because everyone is focused on their own preparation. I feel like I'm the only one lagging behind. At least those living in hostels have company and friends to talk to. Sometimes, I feel lonelier at home - even though I'm with my family."

(Female student, 18, Kota, Field Notes)

The above narrative is consistent with the result obtained while comparing the mental health symptoms of female adolescent staying at home and away from home. Female students staying at home reported feeling of Persistent sadness or Hopelessness, Anxiety or excessive worry, suicidal thoughts more than female students staying away from home (Table 2.18).

(Mueller & Abrutyn, 2016) construct a sociological model that indicates that social participation and regulation disturbances such extreme academic pressure, peer isolation, or strained family relations greatly increase adolescent mental health issue, sometimes even leading to the suicide risk. According to their findings, building social relationships and monitoring student social connectivity could be an important preventive measure.

In the review of 15 years of UK National Confidential Inquiry into Suicide clinical and public health findings, Windfuhr and Kapur stress the significance of comprehensive surveillance of ‘at-risk persons’ and integrated prevention programs - community outreach, school-based screening, and clinical follow-up to improve overall mental health and minimize suicide. Thus, educational institutions need coordinated early warning systems to prevent risk from growing (Windfuhr & Kapur, 2011).

In the present research, the suicidal thoughts issue is reported mostly by the students residing in Jaipur more than it is in Kota which is a surprising result because Kota is usually seen as the epicenter for students’ suicide rate (Table 2.5). Moreover, the mean of average stress among all the respondents across both districts and age groups (15-17 and 17-19) in this study show a concerning Mean Academic stress among the all the symptoms; being highest in case of Suicidal Thoughts that is 4.14, indicating a strong association between high academic stress and suicidal thoughts. (Table 2.6).

It is more concerning since students who are of younger group reported more feeling of suicidal thoughts in comparison to older adolescents (Table 2.16). It indicates that although the older adolescents are more affected by the other mental health issues, they are dealing it better than their younger counterparts. This concern has been probably noticed by the Government of India and it is advised in the Guidelines for Regulation of Coaching Center By Ministry of Education that a coaching center will only be registered if they ‘don’t enroll student below 16 years of age or the student enrolment should be only after secondary school examination’ (Ministry of Education, 2024); probably to decrease the dual burden of school and coaching. The

abovementioned guideline is again repeated in the Code of Conduct of the same document but as observed by the researcher in One year field observation in both the districts, almost no coaching institutes follow this instruction mandated by the Ministry of Education.

Various factors of mental health issues were analyzed against both the age groups, both the districts as well as for place of residence. Anxiety is most prevalent symptom among them all followed by the feeling of Loneliness (Table 2.5, Table 2.16, Table 2.17). The finding is consistent with the study by Balamurugan et al., 2024, which provides compelling evidence that anxiety is one of the most recurring mental health complaints among adolescents, with a reported prevalence ranging from 20% to over 50%. The impact of Anxiety is a widespread issue. Global reports by the World Health Organization emphasize the consequences of anxiety - particularly its impact on school attendance, academic performance, and social withdrawal, which can increase the risk of isolation and loneliness, and in some cases, may escalate into depression or suicidal thoughts. (World Health Organizations, 2024).

The next concerning mental health issue is the constant feeling of Loneliness. While Loneliness standalone may not seem like a major concern, its impact can be severe and long-lasting if not dealt at time and gentle care. Several factors are often linked to loneliness in adolescents - such as staying away from home, separation from familial support systems, and the pressures of rigorous academic schedules (Deb et al., 2016; Hemalatha & Princes, 2024). While it is commonly believed that loneliness may only stem from being away from one's family, insights from recent studies suggest that adolescents may also experience loneliness even when living at home (Bajaj et al., 2024). In the present study, 65.2% students felt anxiety at home in comparison to 54.3% students who were staying away from home. Even more concerning is the data of suicidal thoughts that is more in students staying at home in comparison to staying away from home (Table 2.18).

Another striking finding of this study is the clear age-related increases in psychological vulnerability, with 17–19-year-olds showing significantly higher rates

of loneliness and persistent sadness or hopelessness compared to 15–17-year-olds (Table 2.16). Moreover, the evident upward trend during late adolescence may be attributed to the dual burden of academic stress and gendered cultural norms, which together contribute to increased psychological pressure - particularly in Rajasthan, where the mean age of marriage is 21.5 years to 22.9 years (2017-2020) (Ministry of Statistics and Program Implementation, 2023).

In the qualitative part of the present study, most female students revealed that staying away from home gives them a sense of relief because they can schedule their routine according to their own convenience. This finding is consistent with literature suggesting that autonomy and control over one's environment are critical protective factors for mental health among adolescents. Societal norms frequently require young women especially in India to engage in household duties, and distancing themselves from home seems to liberate them from these daily tiring chores, affording more mental peace and autonomy. Research indicates that the dual burden of academic responsibilities and domestic work disproportionately affects female adolescents, contributing to increased stress, anxiety, and depression (Ram et al., 2014). In previous comparative studies, females reported more mental health issues in comparison to male child as the prevalence of gender discrimination in their households grew. The household environment is a critical setting in which gender inequality is embedded in the intricate web of social life, with related effects on mental health and well-being (Ram et al., 2014). A study examining mental health against the two genders among Indian adolescents found that females from urban backgrounds and nuclear families had significantly poorer mental health than males, attributing this to gender-specific risk factors such as gender discrimination, domestic violence, overwork, and social disadvantages (Majumdar & Srivastava, 2023).

Additionally, several individuals in the present study indicated that an adverse familial situation adversely impacted their mental health, with distance providing essential relief. Research reveals that poor family structure impacts negatively on adolescent mental health (Aggarwal & Berk, 2015; Maheshwari et al., 2020).

A detailed study on the role of family structure found that adolescents from joint families had higher mental health scores than those from nuclear families, suggesting that larger family systems provide better emotional support, emotional ventilation and catharsis. Family should provide love, care, support, and affection towards the child, regardless of the gender and other family members, and should act as a mode of emotional expression and sharing of experiences. The absence of these supportive mechanisms in any nuclear family settings, particularly when amalgamated by gender discrimination and parental pressure, can lead to mental disturbances and distorted psychological functioning in any gender. Behere et al. (2017) highlighted that psychosocial factors, including family structure, have adverse effects on the mental well-being of children and adolescents, emphasizing the need for family-based interventions.(Agarwal & Bahadur, 2023)

Studies have also shown that peer relationships play a very important role at this age especially on the mental health of adolescent (Roach, 2018). Coexisting with own age group, rather than parents, enhanced the emotional well-being of numerous students, indicating the significant influence of supportive peer networks. According to research by the Peer Support Programs for Youth Mental Health, peer support has been shown to improve self-esteem, increase self-confidence, and enhance coping skills among adolescents (Halsall & Raimundo, 2022). Peer support provides validation, understanding, and reduces stigma surrounding mental health issues, creating a safe and non-judgmental space for sharing thoughts and emotions. It found that young people feel more comfortable sharing information about their mental health issues and asking for help with the peers of their own age. The present study's finding that students staying away from home in hostels or paying guest accommodations experience better mental health outcomes can be partly attributed to the availability of peer support networks in such residential settings, where students can share experiences, provide mutual support, and develop healthy coping mechanisms collectively.

A significant proportion of female adolescent students in this study reported feeling comfortable while commuting in Jaipur and Kota, even when living away from home, which can be strongly tied to the recent increased security measures

undertaken in both cities. Out of a total of 560 respondents (290 from Jaipur and 270 from Kota), 240 in Jaipur (82.8%) and 210 in Kota (77.8%) reported feeling safe on their everyday commutes to and from their education institutions. These results indicate that security initiatives such as enhanced street lighting, dedicated women's patrol squads, and greater enforcement of safety regulations in student housing have resulted in a supportive urban environment that enhances physical security for female adolescents (University Grants Commission, 2018).

Despite the enhanced security measures and high reported sense of safety, 440 out of 560 respondents (78.6%) reported at least one mental health symptom. However, only 150 students (34.1%) sought any kind of help, which is evenly split between Jaipur and Kota (75 each) (Table 2.8).

Of the 290 who did not seek help, the majority cited barriers such as the belief that their symptoms would resolve on their own, financial constraints, and stigma (Table 2.11) which is consistent with the findings of the study where stigma related to mental health continues to be one of the major barriers to early intervention (Prabhu et al., 2023; Sharma & Sharma, 2025). In each district, in the present study, 95 students refrained from seeking help because they believed their issues would improve over time (73% in Kota; 59% in Jaipur). The remaining non-help-seekers stated reasons like limited access to mental health resources. Notably, 40% of Kota students and 20% of Jaipur students provided no specific reason for not seeking support. This finding highlights the ubiquitous normalization of mental issues among adolescents, where symptoms such as anxiety, sadness, loneliness, panic attacks, suicidal thoughts among many mental health issues are perceived as transient phases rather than reasonable health concerns requiring professional intervention. The stigma surrounding mental health remains a significant barrier, despite increased policies on the issue. Research indicates that adolescent girls are at risk of having and/or developing mental health problems, yet their help-seeking behavior is limited by poor mental health literacy and social stigma. The lack of awareness about available mental health resources, combined with financial constraints and the absence of accessible services, further compounds the problem (Majumdar & Srivastava, 2023).

Among the 150 students who did seek help, most of them chose therapy or counseling as their preferred intervention, particularly in Kota compared to Jaipur. This preference highlights the value adolescents place on non-pharmacological, supportive interventions that offer a safe space for expression of their emotions. However, the significant geographic disparity in help-seeking behavior suggests that access to counseling services and awareness about their availability vary considerably between the two cities. The higher uptake of therapy in Kota may reflect greater institutional emphasis on mental health support in coaching centers following high-profile suicide cases and subsequent government interventions. The National Mental Health Policy (2014) emphasizes psychological treatments as the first line of care for depression and anxiety, including behavioral activation, cognitive behavioral therapy, interpersonal psychotherapy, and problem-solving therapy. These evidence-based interventions have been shown to be effective in managing adolescent mental health conditions and should be made more widely available and accessible across educational institutions (World Health Organization, 2024)

Despite the prevalence of mental health issues in both cities - Jaipur and Kota - awareness of mental health schemes among female adolescents is significantly low. In Jaipur, only 60 out of 290 female respondents (20.7%) reported being aware of any ongoing programs and schemes, while in Kota, merely 10 out of 270 students (3.7%) were aware of any schemes or programs. This indicates a significant lack of outreach of schemes to the public and highlights a fundamental failure in communication and dissemination strategies by government and institutional stakeholders.

The Supreme Court's 2025 guidelines mandate that all educational institutions maintain anonymized records and prepare annual reports indicating the number of wellness interventions, student referrals, training sessions, and mental health-related activities, which must be submitted to relevant regulatory authorities. However, the mere existence of policies and programs is insufficient if the target population remains unaware of them (*Supreme Court of India Judgment*), 2025).

2.6. Policy Recommendations

The policies for mental health crisis already exist in India. It is only matter of proper implementation followed by thorough Evaluation. The Supreme Court's interim guidelines issued under Article 32 and Article 141 manifest an outstanding judicial intervention in the policy and administrative arena of adolescent mental health. Recognizing the lack of 'a unified, enforceable framework for suicide prevention' in student-centric settings, the Court mandated a comprehensive set of institutional obligations as interim protective measures (Supreme Court, 2025, para. 33).

Central to these is the directive for all educational institutions to 'adopt and implement a uniform mental health policy' informed by national initiatives like Ummeed (Understand, **M**otivate, **E**mpathize, **E**mpower, **D**evelop), Manodarpan, and the National Suicide Prevention Strategy (para. 35-I). There is a clear requirement for periodic review and public accessibility of such policies, fostering transparency and accountability.

The Supreme Court of India has to step in for the Mental health of students- the future of India. The recent *Sukdeb Saha vs. The State of Andhra Pradesh & Ors. (Supreme Court of India Judgment)*, 2025 signifies a pivotal intervention in the student mental health issue, highlighting the necessity for structural transformation. The Court emphasized a statistical crisis, noting that student suicides escalated from 5,425 in 2001 to 13,044 in 2022, with 2,248 fatalities directly linked to examination failure, notwithstanding fragmented interventions by state agencies and organizations. The constitutional right to life as articulated in Article 21 (dignity, autonomy, and mental well-being) are essential components of human rights. Consequently, the Supreme Court has promulgated 15 binding directives, which includes but is not limited to: a standardized mental health policy across all educational institutions; obligatory counsellors in centers with over 100 students; optimal student-to-counsellor ratios with assigned mentors; prohibition of batch segregation and public ranking; biannual staff training on psychological first aid; conspicuous display of helpline numbers (including Tele-MANAS); and safety measures such as tamper-proof ceiling fans in hostels (Supreme Court of India, 2025).

The guidelines emphasize the importance of optimal student-to-counsellor ratios and ‘dedicated mentors or counsellors assigned to smaller batches’, especially ‘during examination periods and academic transitions’, to provide ‘consistent, informal and confidential support’ (para. 35-III). The Supreme Court of India specifically mentioned six cities of India namely Kota, Jaipur, Sikar, Vishakhapatnam, Hyderabad, and Delhi (NCR) (Supreme Court of India, 2025). Two of the crisis cities is dealt in detail in this research.

The prohibition against practices such as ‘batch segregation based on academic performance, public shaming, or disproportionate academic targets’ (para. 35-IV) signifies a recognition of psychological harm caused by hypercompetitive educational cultures. The use of ‘written protocols for immediate referral’ to mental health services and suicide helplines, including Tele-MANAS, ensures institutional responsiveness and bridges emergency and preventive care (para. 35-V).

Repeated mandatory training for all staff in ‘psychological first-aid, identification of warning signs, response to self-harm, and referral mechanisms’ (para. 35-VI) institutionalizes mental health literacy within the education sector’s human resources - an essential step toward normalized mental health support (Supreme Court of India, 2025).

Perhaps the most innovative governance thrust lies in the establishment of a formal, confidential reporting and redressal mechanism for issues such as sexual assault, ragging, harassment, and bullying, managed by internal committees empowered to act swiftly (para. 35-VIII). This redefines institutional cultures by embedding *zero tolerance* for retaliatory actions against complainants and ensuring psycho-social support for victims (Supreme Court of India, 2025)

Ministry of Education’s guidelines for coaching centers should be strictly implemented and continuously evaluated. The Guidelines include but is not limited to (Department of Higher Education, 2024) :

- **General Mental Well-being and Support**

Coaching centers should take steps for the mental well-being of students and conduct classes without putting undue pressure on them, pay due attention to students to check whether they are comfortable or living in distress. If students are found in distress of any kind, there should be a counseling system that should be developed by the coaching center itself for both students as well as parents. Only the trained counselors could be appointed and the information of the psychologists or the counselors should be shared with all the students and their parents who are attending coaching. Psychologists or the counsellors should make sure the students are free of distress.

- **Workshops, Training, and Awareness**

Workshops and sensitization sessions regarding students' mental health should be conducted regularly by the coaching centers for both students and the parents. These sessions should not just focus on mental health but also on the basic training in health, balanced diet, civic sense, disaster management and first-aid. It is imperative that they talk to young minds about the adverse effects of drugs, alcohol etc. The teachers should also be trained regarding mental health issues.

'Positive parenting' should be encouraged in these sessions to increase resilience, responsibility, independence in the youth. Parents should also be counseled about the negative impact of their undue expectations on the young growing mind of a child and an adolescent.

- **Counseling and Guidance**

The counselor's job should be to focus on the students' interests and aptitude. They should be well trained to understand the students' capabilities. It will not only help the students but also the parents to understand their child's mind and save the child from undue expectations. Peer- group interactions should be an integral part of the process.

It is extremely important for the counselors to provide information regarding endless opportunities. Students should be imparted enough knowledge and information that they are able to choose a career if they couldn't clear Medical or Engineering.

Needful students can be identified by their deteriorating performance. Such students should be dealt in confidentiality and with utmost care (Department of Higher Education, 2024).

Various initiatives such as advertisements, billboards, newspaper articles, television advertisements, social media campaigns, and school-based orientation programs can be used to increase awareness regarding mental health schemes and services. Educational institutions must play a proactive role in disseminating information about available resources, including helpline numbers such as Tele-MANAS, institutional counseling services, and government mental health programs.

2.7. Conclusion

This chapter has undertaken a comprehensive examination of adolescent mental health in India, with particular attention to the experiences of female adolescents in the contrasting educational contexts of Jaipur and Kota, Rajasthan. Through an integration of constitutional frameworks, policy analysis, empirical evidence, and qualitative insights, the study has illuminated the multifaceted nature of mental health challenges confronting adolescent girls while also identifying critical gaps in awareness, accessibility, and administrative responsiveness. The findings not only challenge prevailing assumptions about the geographic concentration of student mental distress but also underscore the urgent necessity for evidence-informed, gender-sensitive, and regionally contextualized policy interventions. The recognition of mental health as a fundamental right under Article 21 of the Indian Constitution represents a paradigm shift in how mental well-being is understood and protected within India's legal and policy architecture.

Three major results were found. First, female adolescents in Jaipur report significantly higher rates of mental health distress compared to their counterparts in Kota - a finding that fundamentally challenges the dominant narrative positioning Kota as the epicenter of student psychological crisis. While Kota's high-profile student suicide cases have rightly attracted media and policy attention, the elevated prevalence of anxiety, loneliness, persistent sadness, and suicidal thoughts among female students in Jaipur demands equal, if not greater, urgency in intervention. This

‘Jaipur paradox’ suggests that mental health crises are not confined to high-profile coaching hubs but are pervasive across diverse educational contexts. The higher academic stress levels reported by Jaipur students indicate that competitive pressures, familial expectations, and systemic inadequacies characterizing the Indian educational landscape are widespread and deeply entrenched. The findings underscore that visible manifestations of crisis - such as suicides - represent only the tip of a much larger iceberg of silent suffering, particularly among female adolescents who face compounded pressures arising from gendered expectations and social norms.

Second, the study reveals clear age-related escalations in psychological distress, with older adolescents (17-19) exhibiting significantly higher rates of loneliness and persistent sadness compared to younger counterparts (15-17). This developmental vulnerability coincides with critical life transitions, including approaching marriage age, intensifying academic pressures, and evolving social identities - factors that collectively heighten emotional strain.

Thirdly perhaps the most counterintuitive finding concerns to residential status. Contrary to widespread assumptions that students living away from home experience greater psychological distress, the data reveals that female adolescents residing at home report significantly higher rates of persistent sadness, anxiety, and suicidal thoughts. This pattern suggests that familial environments, while offering physical security, may also be sites of intense pressure, surveillance, and gendered expectations. Qualitative narratives reveal that staying away from home can provide a sense of relief, liberty and autonomy, and freedom from domestic responsibilities and familial judgment, thereby facilitating better mental health conditions, even though it doesn’t guarantee results as expected by the parents. These findings necessitate a critical re-examination of the assumption that home is inherently protective and highlight the need for family-based interventions that address parental expectations, communication patterns, and the gendered division of labor within households.

Despite the high prevalence of mental health symptoms among female adolescents, help-seeking behavior remains alarmingly low, with only 34.1% of symptomatic respondents seeking help. The majority cited beliefs that issues would resolve on their own, financial barriers, lack of access to resources, and stigma. This reflects deep-rooted barriers including normalization of distress, stigma surrounding mental illness, financial constraints, lack of awareness about available resources, and limited institutional support mechanisms. Notably, therapy or counseling emerged as the most preferred form of help, underscoring the value adolescents place on non-pharmacological, supportive interventions. However, awareness of state government mental health schemes is critically low, highlighting a fundamental failure in communication and outreach wherein well-intentioned policies remain invisible to the very populations they are designed to serve. Bridging this gap through targeted awareness campaigns, institutional orientation programs, and community-level mobilization is essential for enhancing the uptake and impact of mental health interventions.

The findings clearly define the deeply gendered nature of adolescent mental health. Female adolescents face intersecting vulnerabilities arising from academic pressures, familial expectations, social norms around marriage and gender roles, and limited autonomy. Research examining women's agency and mental distress reveals that while increased agency in attitudes supporting gender equality correlates with reduced mental distress, increased agency in public speaking or assertive behavior may paradoxically increase distress - reflecting the complex social penalties women face for defying traditional gender norms. These nuanced findings highlight that mental health interventions must be culturally attuned and gender-sensitive, recognizing the specific challenges faced by female adolescents within patriarchal social structures.

The study's findings regarding low satisfaction with institutional mental health support systems and poor awareness of government schemes indicate that current administrative efforts are insufficient. There is a pressing need for proactive outreach, transparent communication, accessible service delivery, and institutionalized accountability. Mental health interventions must be geographically

and contextually nuanced, recognizing that distress is widespread across diverse settings. Interventions must be gender-sensitive, addressing the specific vulnerabilities faced by female adolescents through family counseling, sensitization of parents and community members, institutional policies protecting female students, and empowerment programs. Enhancing help-seeking behavior through awareness campaigns, destigmatization efforts, accessible and affordable counseling services, and institutional mechanisms that normalize mental health care is critical. Administrative responsiveness must be strengthened through capacity building, robust monitoring and accountability mechanisms, inter-sectoral coordination, and participatory policymaking that includes adolescent voices.

Adolescent mental health is not a peripheral concern but a fundamental public health and human rights imperative. The constitutional recognition of mental health as integral to the right to life, combined with the Supreme Court's binding guidelines and the National Mental Health Policy's vision for universal access, provides a robust legal and policy foundation. However, the realization of this vision requires sustained, coordinated, and compassionate action across multiple levels of governance.

This chapter has demonstrated that mental health challenges among female adolescents in Rajasthan are widespread, multifaceted, and deeply rooted in social, cultural, and institutional contexts. The findings challenge dominant narratives, reveal hidden vulnerabilities, and underscore the urgent need for evidence-informed, gender-sensitive, and contextually appropriate interventions. As India navigates the complex terrain of adolescent mental health governance, it must embrace a paradigm that is rights-based, equity-oriented, and participatory—one that recognizes adolescents not merely as passive recipients of policy but as active agents of their own well-being, and that values dignity, autonomy, and emotional well-being as essential to the constitutional promise of life.

Chapter 3

Postpartum Mental Health

CHAPTER 3

POSTPARTUM MENTAL HEALTH

The Objective of this chapter is to understand the Postpartum mental health issues in the state of Rajasthan particularly in Jaipur and Kota districts through the lens of healthcare providers such as the gynecologists, psychiatrists and others.

This chapter is divided **into three sections**.

The **First section** provides an **Introduction** to the chapter with discussion on **National maternal health and Rajasthan's maternal mental health**.

The **Second section** discusses the following in detail:

- **Research Methodology & Profile of Respondents**
 - **Research Question and Approach**
 - **Study Locale and Context**
 - **Study Population and Sampling Strategy**
 - **Data Collection Instruments**
 - **Ethical Considerations**
- **Results**
- **Summary of the key findings**

The **Third section** discusses the following in detail:

- **Discussion**
- **Policy Recommendations**
- **Conclusion**

I

3.1. Introduction

Postpartum mental health in mothers throughout globe plays a crucial role in shaping maternal well-being and overall family functioning. Postpartum psychiatric conditions are classified majorly into three categories (Di Florio et al., 2013; Stewart et al., 2003).

- postpartum blues,
- postpartum psychosis, and
- postpartum depression

When postpartum mental health is taken care of, mothers experience better emotional adjustment and recovery, as seen in cases of postpartum blues which usually resolve within a week with support, attention and care (Stewart et al., 2003). But, when mental health requirements are not addressed adequately, the consequences can be severe. For example, postpartum psychosis, the most severe case of postpartum mental health, although rare, emerges within four weeks after childbirth and often requires hospitalization, demonstrating the serious risks associated with untreated postnatal psychiatric issues (VanderKruik et al., 2017). Similarly, postpartum depression can begin soon after delivery. Without proper treatment, recovery can be disrupted, parenting will be intervened, and long-term maternal mental health issues may arise (Stewart et al., 2003). Therefore, preventing postpartum mental health is essential, as timely interventions and cure help prevent escalation into severe psychiatric conditions and ensure better life for mothers, fathers, infants, and families.

3.2. Indian maternal mental health context

India was the first country to take an initiative on Mental health issues. It launched the National Mental Health Programme in 1982. Despite that, maternal mental health remains insufficiently integrated within national policy and service delivery systems. India has implemented numerous foundational policies concerning maternal and mental health; separately however, none explicitly prioritize postpartum mental health. The National Mental Health Programme (NMHP),

initiated in 1982, underlines the integration of mental health services within primary healthcare. The District Mental Health Programme (DMHP), operational in 767 districts including all 33 districts of Rajasthan, aims to deliver community-oriented mental health services at Community Health Centres (CHCs) and Primary Health Centres (PHCs). However, the National Mental Health Survey (2015-16) indicated that implementation has been insufficient despite comprehensive goals and objectives (Priyadarshini et al., 2023). The Mental Healthcare Act (2017) safeguards the rights of individuals with mental illnesses and mandates integrated mother-infant care during maternal admission for mental health emergencies. However, clinical specialists involved in qualitative research have confirmed that perinatal women have not been acknowledged as a 'special population' like infants and the elderly, despite evidence indicating a high prevalence (Behl et al., 2025). Critically, India lacks a discrete national perinatal mental health policy or plan. The absence creates a foundational void in which state and district-level implementation occurs without strategic direction (Mellers et al., 2025).

Dedicated maternal mental health services continue to be largely absent at most health-care facilities, and frontline health workers often lack adequate mental health training and facilities. As a result, postpartum psychological concerns frequently go unrecognized and then untreated, particularly in settings where specialized mental health professionals are limited or entirely absent in peripheral public health units (Baron et al., 2016). Due to such gaps, mothers face heightened vulnerability to undetected postpartum mental health problems, which can slow down recovery, affect caregiving, and hinder long-term maternal well-being. Thus, prioritizing maternal mental health services and resource-building within the existing health infrastructure becomes essential to safeguarding postpartum women's mental and emotional health.

Moreover, the absence of a designated national screening tool for routine clinical use and lack of systematic data collection further restrict the effective identification and management of postpartum depression in India. Without consistent mechanisms for screening or monitoring perinatal women, the true burden of postpartum mental health conditions remains unknown, and opportunities for early measures are lost

(Baron et al., 2016). This gap accentuates the need for planned assessment, consistent reporting, and trained healthcare workforce. Strengthening these systems would not only facilitate early detection and timely management but would also reflect India's commitment to integrating maternal mental health into the broader public health agenda, improving outcomes for mothers, infants, and families across the country.

3.3. Rajasthan's maternal mental health context

Global estimates suggest that Postpartum depression (PPD) affects roughly 10–20% of women after childbirth (Soni et al., 2025). Even in India, PPD is a significant but under-recognized issue. Recent meta-analyses indicate high burden, though studies vary by region and timing.

Rajasthan instituted the Rajasthan State Mental Health Authority (RSMHA) in September 2024, in accordance with the provisions of the Mental Healthcare Act, 2017. While RSMHA functions as a regulatory authority for overseeing the implementation and registration of mental health facilities, it lacks a dedicated state-level maternal mental health strategy and does not have an allocated budget for perinatal mental health (Government of Rajasthan, 2025b).

The RMNCH+A Strategy designated Rajasthan as 'High Priority Districts' due to inadequate maternal health indicators. High Priority Districts are allocated an additional 30% of resources for general reproductive health, without designated funds specifically for mental health components. Research on RMNCH+A implementation indicates no significant disparity in program efficacy between high-priority and non-high-priority districts, implying that resource allocation alone is insufficient to resolve implementation gaps. In fact, analysis at the state level indicates that larger northern Indian states, including Rajasthan, are unlikely to meet the UN SDG (Sustainable Development Goals) or INAP (India's Newborn Action Plan) targets by 2030 under current implementation trajectories (Das & Yadav, 2023). Data specific to Rajasthan are sparse, but emerging evidence highlights notable prevalence. For instance, a 2025 hospital-based study in Bikaner (northern Rajasthan) reported that 12% of postpartum women screened positive for depression on the Hamilton scale (Soni et al., 2025).

Recent studies have discovered multiple psychosocial correlates: women with a negative obstetric history, little social support, and pregnancy anxiety had higher PPD scores, whereas planned pregnancies and strong supportive relationships had lower scores. These findings are consistent with general patterns in India, where poverty, gender disadvantage (e.g., pressure on male offspring), and household stress have all been linked to prenatal depression, albeit region-specific data are scarce. In short, available data from Rajasthan indicate that a sizable proportion of new moms develop depressive symptoms, often in the setting of persistent socioeconomic and family stress (Soni et al., 2025).

Despite this burden, government responses to PPD have been limited. Maternal health programs in India (including the Reproductive, Maternal, Newborn, Child and Adolescent Health initiative) have traditionally focused on physical outcomes of pregnancy, with little explicit attention to mental health (Priyadarshini et al., 2023). National guidelines now mandate routine postnatal visits by community health workers (ANMs/ASHAs), and these do call for psychosocial support: for example, Indian Ministry of WCD guidelines require ANMs to “assess and counsel” all women during their 2nd and 3rd postnatal visits for any signs of postpartum depression, with referral to higher care if needed (Ministry of Women and Child Development, 2023). Similarly, quality standards for institutional childbirth in Rajasthan (the ‘*Utkrisht*’ initiative) explicitly include screening for PPD based on clinical history and symptoms (O’Neil et al., 2021). *Utkrisht Development Impact Bond (DIB)*, The world's first maternity and newborn health bond, founded in 2018, will fund improvements in quality of care aimed at lowering maternal and neonatal mortality rates in the state of Rajasthan, India, over a five-year period.

These are nascent toward integrating maternal mental health into regular care. In 2023, the Indian Council of Medical Research approved a project to scale up a prenatal depression program in rural Rajasthan, with the goal of adapting lay-counsellor models for local circumstances.

Nonetheless, **no dedicated scheme or funding stream** exists for postpartum depression at state or national level. Broad mental health policy in India has so far

overlooked maternal needs: reviews note that the National Mental Health Program and the National Mental Health Policy (2014) did **not** recognize perinatal women as a key target group (Priyadarshini et al., 2023). In Rajasthan, mental health services remain scarce both in rural and urban areas. Even the biggest hospitals don't have enough facilities to address the issue, let alone community services. In practice, therefore, many cases of PPD likely go unrecognized and untreated. Although while some guidelines mandate PPD screening, comprehensive government action (such as training, care pathway, or psychosocial services for new mothers) is largely absent.

These gaps underscore the need for focused study. A rigorous appraisal of PPD prevalence, determinants, and care gaps in Rajasthan can inform policy. In particular, identifying the scale of PPD and the barriers to care will justify interventions (for example, training ASHAs in mental health, or adding maternal mental health to state health missions). Rajasthan's maternal health landscape reflects significant structural and socio-demographic challenges that make postpartum mental health support particularly critical. The data given show remarkable gains in maternal health in Rajasthan over time, with the maternal mortality ratio (MMR) falling from 627 per 100,000 live births in the early 1980s to around 445 per 100,000 by 2001-2003. Institutional deliveries climbed dramatically, reaching nearly 32% by 2005-2006, while the proportion of newborns attended by health professionals increased to 43% during the same period. Despite these advances, urban-rural inequities remain, with urban women seeking institutional delivery support more than twice as frequently as rural women. Antenatal care coverage increased from 33% in 1992-1993 to 73% in 2005-2006, however anemia remained common among women, with 51.4% affected in 1998-1999 and rising to 61% in 2005-2006. Furthermore, nearly half of maternal deaths are due to reasons such as hemorrhage and anemia, highlighting persisting maternal health issues, particularly in rural and tribal populations (S. D. Iyengar et al., 2009).

In a situation where maternal undernutrition, high parity, and biological risk factors remain pressing, incorporating postpartum mental health screening and assistance

into Rajasthan's maternal health system is critical to ensuring holistic maternal well-being after childbirth (S. D. Iyengar et al., 2009).

Postpartum mental health in India and Rajasthan reveals a significant disparity in policy implementation due to structural, administrative, and systemic challenges. Despite the existence of various national policies (such as the National Mental Health Program, the Mental Healthcare Act 2017, RMNCH+A, and others), their implementation remains fragmented across state and local levels. This disparity is most evident in Rajasthan, where maternal mental health has not been incorporated.

II

3.4. Research Methodology

3.4.1. Research Question and Approach

Research Question

What are healthcare professionals' perspectives on the risk factors, barriers, and management approaches for postpartum mental health issues in Rajasthan?

This study used a **mixed-methods research design combining quantitative, qualitative and descriptive research components**. The mixed-methods approach was selected to triangulate data sources and provide both depth and breadth of understanding regarding healthcare professionals' perspectives on postpartum depression in Rajasthan's urban healthcare settings.

The qualitative angle provided narratives and emergent patterns from professionals' clinical experiences, observations, and interpretations. The quantitative dimension offered frequency distributions, percentages of the issues.

Rather than exclusively examining individual patient experiences (which may vary with the mood of mother and her personal experience and many mother themselves are unaware of the issue), this study centers healthcare professionals as primary data sources. Professionals' perspectives are theoretically valuable because each practitioner has observed many clinical encounters. A single gynecologist in a high-

volume government hospital manages thousands of deliveries annually (approx.) - providing observational data vastly exceeding what individual patient interviews could generate. This approach required a design capturing both the **breadth of patterns** (quantitative frequencies) and the **depth of explanations** (qualitative interpretation).

3.4.2. Study Locale and Context

Geographic Selection: Jaipur and Kota, Rajasthan

Research was conducted in **Jaipur and Kota**, two major urban centers in Rajasthan, India, purposively selected for their distinct but complementary healthcare contexts.

Jaipur (State Capital)

- Serves as Rajasthan's administrative center and largest urban center
- Reflects diverse population from across Rajasthan, and patients who come from all parts of Rajasthan for treatment.
- Contains approximately 12 major government hospitals and numerous private hospitals.
- Includes tertiary care and secondary care facilities serving urban, semi-urban, and referred rural populations.

Kota (Medical and Educational Hub)

- Recognized as a significant medical education center with multiple teaching hospitals.
- Presents a different urban healthcare context different from state capital dynamics.
- Contains approximately 5 significant government hospitals alongside private hospitals.

Healthcare Infrastructure and Delivery Context

Both cities serve as major maternal healthcare hubs with significant institutional delivery infrastructure:

- **High-Volume Government Hospitals:** Principal tertiary hospitals in Jaipur and Kota manage several thousand deliveries monthly. Based on reported daily delivery volumes (20–25 cesarean sections and 25–33 vaginal

deliveries daily in major government hospitals), these institutions conduct approximately 16,000–18,000 deliveries annually per facility, reflecting their critical roles as state-level maternal healthcare providers (approximate numbers).

- **Healthcare System Diversity:** The inclusion of both government and private facilities in both cities enabled examination of postpartum mental health across diverse institutional contexts and patient's demographics. This healthcare context is critical for understanding the study's findings: healthcare professionals such as doctors, psychologists from these hospitals possess observational experience spanning hundreds of thousands of maternal encounters, providing perspectives on population-level patterns in postpartum mental health.

3.4.3. Study Population and Sampling Strategy

Population Definition

The study population comprised **healthcare professionals actively practicing in maternal healthcare settings in Jaipur and Kota**, specifically individuals involved in obstetric care, maternal health management, or postpartum care provision.

Sample Composition

The final sample consisted of **52 healthcare professionals** from Jaipur and Kota combined:

Professional Composition (n=52):

- Gynecologists: 34 (65.4%) - primary obstetric care providers and frontline observers of maternal mental health
- Psychiatrists: 7 (13.5%) - adding specialized mental health expertise and clinical perspectives
- MBBS-trained General Physicians: 6 (11.5%)
- Others (Block Managers, Assistant Professors, specialists): 5 (9.6%)

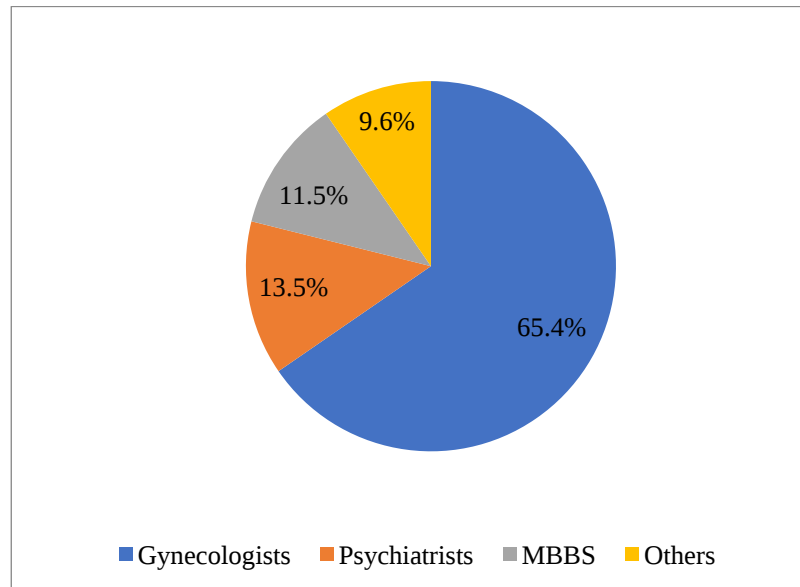


Figure 3.1: Professional composition of respondents.

Figure 3.1. shows that more than 50% of the respondents are Gynecologists and seven Psychiatrists who have first-hand experience with the new mothers.

Following figure 3.2. represents the Clinical Experience:

- 0–5 years' experience: 32 (61.5%)
- 6–10 years' experience: 4 (7.7%)
- 11–15 years' experience: 8 (15.4%)
- 15 years' experience: 8 (15.4%)

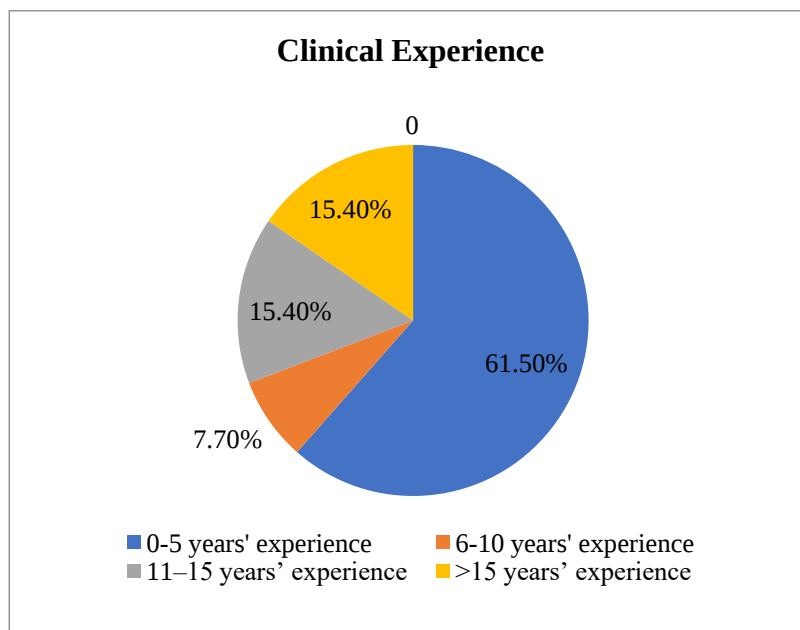


Figure 3.2: Clinical experience of the respondents

Inclusion Criteria

Participants were selected based on the following inclusion criteria:

1. **Minimum Clinical Experience:** At least ≥ 1 year of active clinical practice in maternal healthcare settings
 - *Rationale:* Ensures professionals possessed enough clinical experience to postpartum cases.
2. **Institutional Capacity:** The hospital got enough patients with more than 10,000 deliveries annually (both vaginal and caesarean).
 - *Rationale:* Ensures exposure to enough maternal cases for reliable observational patterns.
3. **Clinical Caseload:** Each professional had personal clinical experience with $\geq 5,000$ patients over their career
 - *Rationale:* Ensures deep clinical insight and pattern recognition across large numbers of cases.
4. **Active Practice:** Currently engaged in maternal healthcare as doctor, psychologists or consultation
 - *Rationale:* Ensures current knowledge with current postpartum mental health challenges and management approaches.

Sampling Strategy

Sampling Method: Purposive and convenience sampling.

Purposive Component: Healthcare professionals were deliberately selected based on **expertise and institutional context** - specifically from major tertiary care hospitals with high patient volumes, well-recognized for their maternity services in Jaipur and Kota.

Convenience Component: Selection criteria also incorporated convenient availability and willingness to participate.

Sample Size Justification: The final sample of 52 healthcare professionals provided professional depth. It collectively represented approximately **376 years of cumulative clinical experience** (mean ≈ 7 years per respondent) and observation of

many thousands of maternal cases, providing substantial data depth despite a modest sample size.

3.4.4. Data Collection Instruments

Questionnaire Development

Data were collected using a **structured questionnaire** through Google Forms and Personal Interviews.

Development Process:

1. Extensive literature review on postpartum depression, risk factors, cultural influences, and healthcare barriers
2. Thematic synthesis of key domains affecting postpartum mental health
3. Pilot research with 3–5 healthcare professionals to assess clarity, relevance, and feasibility of the questionnaire.

Questionnaire Structure and Domains:

The final questionnaire comprised 24 items that were thematically organized:

Section 1: Demographic and Professional Context (Q1–4)

- Q1: Professional designation
- Q2: Years of healthcare practice experience
- Q3: Type of healthcare facility
- Q4: Geographic location of practice

Section 2: Risk Factors for Postpartum Depression (Q5–7)

- Q5: Significant risk factors for PPD (biological, psychological, social)
- Q6: Family-related factors associated with Postpartum mental health issues
- Q7: Delivery-related or childbirth factors associated with Postpartum mental health issues

Section 3: Cultural and Societal Influences (Q8–9)

- Q8: Societal and cultural expectations' influence on maternal mental health
- Q9: Cultural beliefs in Rajasthan that impacts Postpartum mental health issues recognition and treatment

Section 4: Prevalence and Diagnosis (Q10)

Q10: Estimated percentage of women clinically diagnosed with Postpartum mental health issues per 1,000 births

Section 5: Barriers to Management (Q11–13)

Q11: Barriers to effective Postpartum mental health issues management in healthcare facilities

Q12: Maternal awareness of mental health services

Q13: General public awareness of Postpartum mental health issues

Section 6: Help-Seeking and Support Systems (Q14–15)

Q14: Percentage of mothers seeking professional help for Postpartum mental health issues.

Q15: Support systems for mothers with Postpartum mental health issues

Section 7: Healthcare Provider Role and Policy Context (Q16–20)

Q16: Perceived Association Between Maternal Education and Postpartum mental health issues

Q17: Healthcare providers' roles in addressing Postpartum mental health issues

Q18: Local/State Government initiatives for postpartum mental health

Q19: Central government schemes for maternal mental health

Q20: Perceived effectiveness of government initiatives

Section 8: Long-term Effects and Future Directions (Q21–23)

Q21: Whether Post partum Depression is a "disease of modern civilization"

Q22: Long-term effects of untreated Postpartum mental health issues in mothers

Q23: Additional resources/policies needed for Postpartum mental health issues support

Question Formats

The questionnaire employed **mixed question formats** to capture both quantitative and qualitative data:

1. Closed-Ended Multiple-Choice Questions (demographic items)

- Example: Q1 (Designation), Q3 (Facility type)

- Purpose: Generate categorical frequencies
2. **Multiple-Response Checkbox Questions**
 - Example: Q5 (Risk factors), Q6 (Family factors), Q15 (Support systems)
 - Purpose: To understand Various multi-layered reasons for Postpartum mental health issues in mothers.
 - Analysis: Frequency of each option reported as percentage of respondents selecting it
 3. **Likert-Scale Questions** (ordinal responses)
 - Example: Q9 (Cultural beliefs' influence: "significantly hinder" to "little impact")
 - Example: Q20 (Initiative effectiveness: "very effective" to "not effective")
 - Purpose: To capture the degree of perception.
 4. **Percentage-Based Estimation Questions** (quantitative estimates)
 - Example: Q10 (% clinically diagnosed), Q14 (% seeking help)
 - Purpose: Generate clinician estimates of help-seeking behavior.
 5. **Open-Ended Questions** (narrative responses)
 - Example: Q8 (Observational narrative), Q23 (Recommendations)
 - Purpose: Capture qualitative narratives, recommendations, and unnoticed themes/issues.

Primary data collection was conducted over six months duration, spanning January 2025 to July 2025, across Jaipur and Kota districts.

3.4.5. Ethical Considerations

Verbal informed consent was taken from all participants, ensuring they understood the study purpose, confidentiality protections, and their right to withdraw at any time. Confidentiality was rigorously maintained by anonymizing questionnaires and securely storing data with access only to the researcher.

No patients were involved in this study - data were collected exclusively from healthcare professionals. The study posed minimal risk and ensured respectful, voluntary participation.

3.5. Results

3.5.1. Risk Factors for Postpartum Depression (Q5-7)

This section comprises of risk factors comprising of biological, psychological, social-risk, family-related, delivery-related, childbirth factors as identified by the healthcare professionals.

a) Biological, Psychological, and Social Risk Factors (Q5)

Table 3.1: Identified Risk Factors for Postpartum Mental health issues (N=52) (Respondents can choose more than one option)		
Risk Factor	N=52	%
Female child born in current pregnancy	36	69.2
Financial difficulties	36	69.2
Past history of psychiatric illness/anxiety/low mood	36	69.2
Low maternal education	32	61.5
Child care related stressors	28	53.8
Congenitally malformed infant	24	46.2

Table 3.1. identifies six risk factors that may lead to mental health issues after delivery. The issues are biological, psychological and social. 69.2% respondents chose Female child born, financial difficulties and past history of psychiatric illness or anxiety as the major risk factors. Other three factors too are considered major factors making a total of more than five factors above 50% according to the healthcare providers.

b) Family-Related Factors (Q6)

Table 3.2: Family-Related Factors Associated with Postpartum Mental health issues (N=52) (Respondents can choose more than one option)		
Family Factor	N=52	%
Lack of partner support	40	76.9
Lack of family support	36	69.2
Marital discord	28	53.8
Living in nuclear family	24	46.2
Partner alcoholism	24	46.2
Living in joint family	8	15.4

Table 3.2. underscores that **Family-related factors** can also contribute significantly in Postpartum mental health conditions adversely. Lack of partner support followed by lack of family support is the leading factor in this category. **Living in joint family is the least contributing factor to mental health issues postpartum.**

c) Delivery-Related and Childbirth Factors (Q7)

Table 3.3: Delivery-Related Factors Associated with Postpartum Mental health issues (N=52) <i>(Respondents can choose more than one option)</i>		
Delivery-Related Factor	N=52	%
Unplanned pregnancy	36	69.2
Multiple pregnancies (twins, triplets)	20	38.5
Cesarean delivery	16	30.8
Normal vaginal delivery	8	15.4

Table 3.3. highlights the delivery related factors that may contribute to the postpartum mental health issues. Unwanted pregnancy has the highest risk for postpartum mental health issues. Normal vaginal delivery, though least probable is yet a possible reason for postpartum mental health issue.

3.5.2. Societal and Cultural Influences (Q8-9)

This section discusses the societal and cultural influences that may influence postpartum mental health issues in mothers.

a) Societal Expectations (Q8)

Table 3.4: Societal Expectations Influencing Maternal Mental Health (N=52) <i>(Respondents can choose more than one option)</i>		
Expectation/Pressure	N=52	%
Gender preference pressure	40	76.9
Pressure to return to normal roles quickly	32	61.5
Expectation to prioritize child over personal health	28	53.8

Table 3.4. discusses Societal Expectations that influences the maternal mental health. **All the three listed reasons are marked above 50%** by the healthcare

professionals that include Gender preference pressure followed by the pressure to return to normal roles of being a mother, wife and other relations as soon as possible and unfair expectation to prioritize child's health while her own health takes a backseat.

b) Cultural Beliefs (Q9)

Table 3.5: Impact of Cultural Beliefs on Postpartum Mental Health Recognition and Treatment (N=52)		
Cultural Beliefs	N=52	%
Significantly hinder recognition and treatment	24	46.2
Somewhat influence recognition and treatment	16	30.8
Not sure	8	15.4
Little to no impact	4	7.7

Table 3.5. identifies what percentage of healthcare providers believe that cultural beliefs impact mothers. And 46.2% of healthcare providers believe that cultural beliefs have significant hindrance over recognition and treatment of postpartum mental health issues in Rajasthan.

3.5.3. Prevalence and Diagnosis (Q10)

Table 3.6. Estimated Percentage of Women Clinically Diagnosed with PPD per 1,000 Births (N=52)		
Diagnosis Rate	N=52	%
No such data available	16	30.8
0–10%	24	46.2
10–20%	4	7.7
40–50%	4	7.7
50–60%	4	7.7

Table 3.6 notes the estimated percentage of women clinically diagnosed with Postpartum depression per thousand births in Rajasthan. It is important to note that this data is an estimation by the healthcare professionals and not the recorded the data by the hospitals. Twenty four out of fifty-two professionals noted that on an

average 0-10% mothers are suffering from postpartum depression in Rajasthan. It is important to note that 31 percent of healthcare providers mentioned that no data is officially noted for the same.

3.5.4. Barriers to Management (Q11–13)

Following section highlights the various barriers to management in managing the mental health issues in Rajasthan.

a) Barriers to effective Postpartum mental health management in healthcare facilities (Q11)

Table 3.7: Barriers to Effective PPD Management (N=52) <i>(Respondents can choose more than one option)</i>		
Barrier	N=52	%
Lack of awareness among mothers	20	38.5
Availability of mental health professionals	16	30.8
Fear of stigma among patient's families	16	30.8
Availability of mental health professionals	12	23.1
High patient-to-provider ratio	4	7.7
Inadequate maternity leaves policies	0	0.0
All of the above	24	46.2

Table 3.7. finds a very intriguing result that many factors contribute to effective management of postpartum mental health issues in Rajasthan. Major contributing factors as marked by the healthcare professionals are Lack of awareness among the mothers followed by availability of mental health professionals and the fear of stigma among many other factors.

It is important to note that inadequate maternity leave policies is not opted by a single healthcare provider.

b) Maternal Awareness of Mental Health Services (Q12)

Table 3.8: Mothers' Awareness of Mental Health Services in Healthcare Facilities		
Response	N=52	%
No	28	53.8
I don't know	20	38.5
Yes	4	7.7
Combined No/Unsure	48	92.3

Table 3.8 notes that **more than 50% of healthcare professionals** believe that Mothers are not aware of any mental health services that are available in the healthcare facilities whereas 38.5% are unaware whether or not the mothers are aware of the same.

The data is represented through pie-chart below.

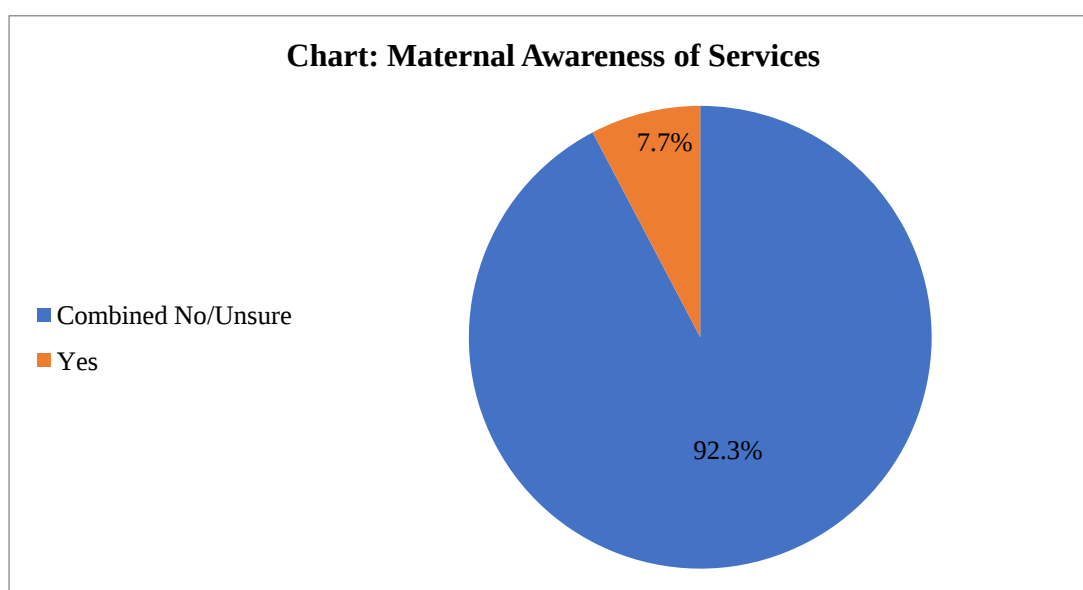


Figure 3.3: Mothers' Awareness of Mental Health Services in Healthcare Facilities

Figure 3.3. represents how aware the mothers are according to the Healthcare providers about the healthcare facilities. 92.3% of the total respondents say that the mothers are available of the services whereas only 7.7% of the respondents were either unsure or sure that they didn't know about the same.

c) General Public Awareness of PPD (Q13)

Table 3.9: General Public Awareness of PPD and Symptoms		
Awareness Level	N=52	%
Somewhat aware	24	46.2
Not very aware	24	46.2
Not at all aware	4	7.7
Very aware	0	0.0

Table 3.9 mentions general public awareness (other than the mother herself) regarding the mental health issues postpartum, as experienced by the Healthcare providers. **46.2% of the professionals believe that the general public is not very aware of the issue and its remedies while other 46.2% of professionals believe they are somewhat aware of the issue. None of them believe that anyone is very well aware of the issue in Rajasthan.**

3.5.5. Help-Seeking and Support Systems (Q14–15)

Following section discusses the help-seeking behavior and available support systems for the same in the state of Rajasthan.

a) Percentage of mothers seeking professional help for Postpartum mental health issues (Q14)

Table 3.10: Percentage of Mothers Seeking Professional Help for Postpartum mental Health Issues		
Help-Seeking Rate	N=52	%
<10%	36	69.2
10–20%	12	23.1
>20%	4	7.7

Figure 3.10 highlights that less than 10 percent of mothers seek professional help even if they are suffering, as noted by 69.2% professionals.

b) Support systems for mothers with Postpartum mental health issues (Q15)

Table 3.11: Support Systems Believed Most Beneficial (Respondents can choose more than one option)		
Support System	N=52	%
Support from extended family	44	84.6
Access to professional mental health services	40	76.9
Community outreach programs (ASHA workers)	32	61.5
Local peer support groups	24	46.2

Figure 3.11 mention the support systems that are most valuable for the mothers who have recently given birth or are suffering from postpartum mental health issues. The support system believed to be most beneficial are support from the extended family (84.6%) and if they have access to professional mental health services (76.9%) and additionally if there are community outreach programs by the ASHA workers (61.5%) for the same. The same is represented through horizontal bars below.

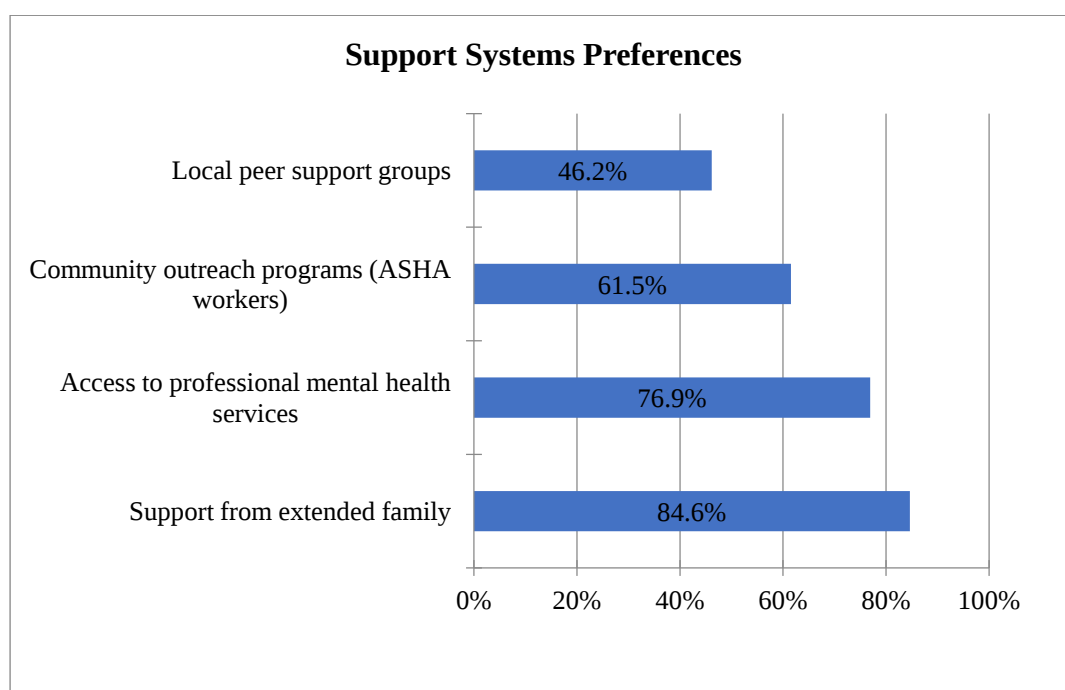


Figure 3.4: Horizontal bars representing the support system preferences by the needful

3.5.6. Healthcare Provider Role and Policy Context (Q16–20)

a) Perceived Association Between Maternal Education and Postpartum mental health (Q16)

Table 3.12: Perceived Association Between Maternal Education and Postpartum mental health		
Educational Level	N=52	%
Similar prevalence across all educational levels	16	30.8
No formal education	16	30.8
Primary education	12	23.1
Higher education (undergraduate and above)	8	15.4

Table 3.12. analyses the association between the education level of the mother and if they suffer from any postpartum mental health issues. 30.8% of healthcare providers note that it is similar across all educational levels meaning that education doesn't have any impact of whether they suffer from postpartum mental health issue or not. On the other hand, equal proportion of healthcare providers noted that mothers who never got any formal education are more prone to suffer from mental health issues postpartum.

b) Healthcare providers' strategies in addressing Postpartum mental health issues (Q17)

Table 3.13: Healthcare Provider Strategies (Respondents can choose more than one option)		
Provider's Role	N=52	%
Providing emotional support and referrals to mental health services	40	76.9
Identifying depressive thoughts	24	46.2
Applying behavioral modification techniques	24	46.2
Assisting with decision-making	24	46.2
Providing practical support through problem-solving	20	38.5
Only diagnosing the condition	16	30.8
Implementing communication strategies	16	30.8
Building personal connections with new mothers	16	30.8
Using group psychotherapy techniques	12	23.1
Focusing solely on physical health	8	15.4

Table 3.13 enlists many strategies that is used by the healthcare providers to deal with the issue of postpartum mental health issues faced by the mother; providing emotional support and referrals topping the list with almost 77%. Identifying depressive thoughts during regular infant checkups in the mothers and applying behavioral modification techniques using communication and assisting with decision-making is followed right after with 46.2% each.

It is important to note that 30.8% note that they only diagnose the condition without doing anything to help the mothers.

c) Local/State Government initiatives for postpartum mental health (Q18)

Table 3.14: State Government Initiatives to Address Postpartum Mental Health (Respondents can choose more than one option)		
Initiative	N=52	%
No such initiatives are currently being taken	28	53.8
Collaborating hospitals with NGOs and ASHA workers	24	46.2
Integrating mental health screening in routine visits	8	15.4
Specialized training for healthcare providers	4	7.7

Table 3.14. notes how State Government acts to address postpartum mental health issues in Rajasthan according to the healthcare professionals. 53.8% note that no such initiatives are being taken by the government to address the grave concern whereas 46.2 % note that the state government try to collaborate the hospitals with the NGOs and ASHA workers for the same.

d) Central government schemes for maternal mental health (Q19)

Table 3.15. Central Government Schemes Impacting Maternal Mental Health (Respondents can choose more than one option)		
Scheme/Program	N=52	%
Maternity leave policies	36	69.2
Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA)	32	61.5
Community support programs (ASHA workers, ANMs)	28	53.8
National Mental Health Program (NMHP)	16	30.8
National Mental Health Care Act, 2017	12	23.1
District Mental Health Program (DMHP)	8	15.4

Table 3.15. note that the Maternity Leave Policies have been taken in the direction of improving the maternal mental health (as noted by 69.2%) by the Central Government followed by the PMSMA as noted by 61.5% of healthcare providers. Community Support Systems like ASHA and ANM are also a noteworthy step by the Central Government for maternal health, as noted by the 53.8% of the respondents.

e) Perceived effectiveness of government initiatives (Q20)

Table 3.16: Perceived Effectiveness of State/Local Government Initiatives		
Effectiveness Rating	N=52	%
Somewhat effective	44	84.6
Not effective	4	7.7
No initiatives in place	4	7.7
Very effective	0	0.0

Table 3.16 estimate that although the initiatives by the Government at various levels are effective but it is important to note that none of them reported that it is very effective. It means the problem remains despite the efforts. 84.6% of the respondents say it is somewhat effective.

3.5.7. Long-term Effects and Future Directions (Q21–23)

a) Postpartum depression as modern Phenomenon (Q21)

Table 3.17: Is Postpartum Depression an issue of Modern Civilization?		
Response	N=52	%
Yes	32	61.5
No	20	38.5

Table 3.17 explores a very important question that whether or not the postpartum depression a modern phenomenon and **61.5% of respondents note that it is a modern issue**. Although 20 of the respondents believe that the issue has always been there.

b) Long-term effects of untreated Postpartum mental health issues in mothers (Q22)

Table 3.18: Long-Term Effects of Untreated Postpartum mental health issues (Respondents can choose more than one option)		
Long-Term Effect	N=52	%
Relationship issues with partners or family members	40	76.9
Impact on mother-child bonding	28	53.8
Ongoing mental health challenges	28	53.8
Changes in parenting style	20	38.5
No noticeable long-term effects	4	7.7

Table 3.18 answers a very deep future issue that may arise if postpartum mental health of mothers that require help is unmet with desirable aid (76.9%). Issues such as fragile relationship with partner and family members or impact on child-mother bond (53.8%) or even worse, continued mental health challenges, if the current issue is not taken care of as mentioned by 53.8% respondents.

3.6. Summary of Key Findings

- Sample comprised 52 healthcare professionals; 65.4% gynecologists, **376 years of cumulative clinical experience** (mean $\approx$ 7 years per respondent).
- Top risk factors: Gender preference pressure (76.9%), lack of partner support (76.9%), female child birth (69.2%), unplanned pregnancy (69.2%).
- Cultural beliefs significantly hinder Postpartum mental health recognition/treatment (46.2%).
- Maternal awareness of services extremely low (7.7% aware, 92.3% unaware/unsure).
- Help-seeking rates very low (less than 10% according to 69.2% of respondents i.e., 36 out of 52 respondents).
- Extended family support most beneficial (84.6%), followed by access to professional mental health services (76.9%) to deal with the mental health crisis after child birth for the mothers.
- Majority (53.8%) of the healthcare providers report no state government initiatives to address the postpartum mental health issue in the state of Rajasthan.

- Existing initiatives rated only ‘somewhat effective’ (84.6%).
- Long-term effects: relationship issues (76.9%), bonding disruption (53.8%), ongoing mental health challenges (53.8%).
- Current strategies to deal with the postpartum mental health crisis include Providing emotional support and referrals by the healthcare providers (76.9%).
- Healthcare providers are having split opinion on association between education of mothers and postpartum mental health issue; 30.8 % split between similar prevalence across all educational levels and no formal education, each.
- Even though the issue is prevalent in Rajasthan (more than 10% per 1000 birth according to 46.2% of the respondents), the awareness of General Public is low. Not a single respondent mentioned that the Public is ‘very aware’.
- 92.3 % of the respondents believe that even the mother is unaware or unsure (combined data) of the services for mental health issues postpartum.

III

3.7. Discussion

The present research gives a thorough understanding of healthcare providers’ views on Postpartum mental health of mothers in the state of Rajasthan. This new approach helps us understand the opinion of the doctors such as gynecologists, psychiatrist, Professors working in the similar field. This research is a diversion from the previous studies on Postpartum mental health which underscores the opinion of the patients on the same. Previous studies have focused on the postpartum mental health of mothers (Lodha & Sousa, 2022; Nigam et al., 2016) using the Edinburgh Postnatal Depression Scale (EPDS) (Nigam et al., 2016). While individual mothers offer invaluable first-person accounts of their experiences which is crucial in understanding the lived experience of postpartum mental health issues such as postpartum blues, depression and psychosis, their perspective is inherently limited to their own singular case. A single mother can speak authoritatively only about her own journey through postpartum mental health challenges but the healthcare

providers provide unbiased and expert opinion on the issue and can underline the gravity of the issue with their experience.

Each doctor or healthcare provider working in obstetrics, gynecology, psychiatry, or general practice encounters dozens, if not hundreds or thousands of cases annually in the present study. The major hospitals in Rajasthan does 16,000 to 17,000 deliveries per year (Gandhi, 2020; Haaland & Sitaraman, 2022). This delivery load reflects the high volume of obstetric cases seen in tertiary government hospitals in Rajasthan. As part of a multidisciplinary team, individual gynecologists attend and supervise a subset of these deliveries, with personal caseloads varying according to staffing and duty rotations. This concentrated clinical experience creates an invaluable lens for understanding the existent crisis, beliefs and patterns, risk factors, cultural and social influences, protective factors, and systemic barriers to care that emerge only when observing hundreds to thousands of cases rather than examining a single case in isolation.

Furthermore, healthcare professionals observe not merely the patient's subjective perspective but also the family dynamics, the social and cultural context of maternal distress, the interaction between mental health symptoms and systemic healthcare failures, and the longitudinal consequences of untreated depression. They witness what mothers may not articulate due to the lack of understanding and literacy regarding the same, shame and stigma, or lack of awareness; the doctors and psychiatrists recognize symptoms that patients themselves may not acknowledge, understand or misunderstand; and they observe the broader societal and cultural forces shaping maternal mental health outcomes across diverse populations. When a patient describes her own emotional experience, a doctor describes patterns observed across many women, making their testimony richer in terms of population-level insights. In high-volume tertiary care government hospitals in Rajasthan especially in capital city Jaipur and urban hub Kota serving large populations, thousands of deliveries occur annually; patients coming from all over Rajasthan (Haaland & Sitaraman, 2022). These institutions represent microcosms of broader population trends and challenges in maternal mental health.

This approach represents a genuinely novel methodological contribution to the literature on postpartum mental health. By centering the voices, observations, and clinical expertise of healthcare professionals, this study provides a complementary and essential perspective to existing patient-centered research, creating a more complete understanding of postpartum depression as a phenomenon shaped by individual vulnerability, family dynamics, healthcare system capacity, cultural beliefs, and policy failures. The research demonstrates that truly comprehensive understanding of maternal mental health requires understanding not only from those who experience it, but equally from those who observe it as an expert across populations—a distinction that has methodological significance and ethical implications for evidence-based maternal health interventions.

The present study sample comprised 52 healthcare professionals from urban settings in Jaipur and Kota, Rajasthan. The majority (65.4%) were gynecologists, with psychiatrists (13.5%), general physicians (11.5%), and other specialists (9.6%) also represented. Most respondents (61.5%) had 0–5 years of clinical experience, while 15.4% each had 11–15 years or more than 15 years of experience. The sample was drawn predominantly from government hospitals (53.8%), with representation from private hospitals (23.1%), private clinics (15.4%), and community health centers (7.7%), ensuring a diverse range of healthcare settings and professional perspectives.

Among the biological, psychological, and social risk factors identified, gender preference pressure and lack of partner support emerged as the most commonly cited factors, each identified by 76.9% of respondents. Female child birth (69.2%), financial difficulties (69.2%), and past history of psychiatric illness, anxiety, or low mood (69.2%) were also frequently recognized as significant risk factors. Low maternal education was identified by 61.5%, while child care related stressors were noted by 53.8%. Notably, congenitally malformed infants (46.2%) and lack of supportive family members (7.7%) represented the lower end of identified risk factors.

These findings align with research demonstrating that unplanned pregnancy, multigravidity, history of abortion, current obstetric complications and advancing pregnancy are associated with increased likelihood of postpartum depression (Ajinkya et al., 2013; Arora & Aeri, 2019; Tsakiridis et al., 2019).

Gender preference pressure emerged as the dominant cultural force, identified by 76.9% of respondents as shaping maternal mental health. It reflects the unfortunate existence of gender preference still prevalent in Rajasthan. The prevalence and its impact are so severe that it is one of the concerning factors and a contributing reason to postpartum mental health crisis in Rajasthani mothers. According to the present study approximately 70% of the healthcare providers have witnessed birth of female child as one of the reasons in their clinical experience. Societal and cultural expectations profoundly influence maternal mental health in the Rajasthan's context. This pressure manifests as disappointment when female children are born, blame directed at mothers, reduced care and support, and internalized guilt and shame among mothers themselves. Healthcare professionals observed that mothers who give birth to female children, particularly in families that already have daughters or where there is explicit desire for male children, face significant psychological distress. The gender preference pressure does not discriminate by education or economic status, appearing to be a deeply rooted cultural issue affecting diverse populations (Hegde et al., 2013; Shidhaye et al., 2017).

Beyond gender preference, 61.5% of respondents identified pressure on mothers to return to normal roles quickly as a significant cultural expectation, while 53.8% recognized that mothers are expected to prioritize the child over their own health. These cultural norms contribute to maternal exhaustion and depression, particularly in economically disadvantaged families where the mother's labor remains economically necessary despite recent childbirth. Healthcare professionals noted that new mothers face expectations to resume household duties, cooking, cleaning, and even fieldwork or employment with minimal recovery time, effectively shrinking traditional postpartum rest periods. Similar results have been shown by previous researches where gender preference leads to antenatal depression in mothers (Arora & Aeri, 2019; Shidhaye et al., 2017; Takegata et al., 2017).

As observed by the healthcare providers in the current study of Rajasthan, lack of partner support does not only lead to postpartum depression in mothers but is in fact one of the leading causes for it; 76.9% of respondents reporting it. The result is supported by previous studies on mothers which suggests that lack of partner support is far worse than being a single mother (Bilszta et al., 2008). Lack of partner support include taunt, trauma and other forms of negligence that may lead to depression in mothers (Biaggi et al., 2016; Cheng et al., 2014; Galbally et al., 2019; Hildingsson et al., 2008; Raymond, 2009).

Financial difficulties too contribute to postpartum distress in mothers. As per the present study, 69.2% of healthcare providers believe that their patients have suffered from the mental health crisis due to the same. Some previous studies have gone as far to report financial issues as the leading cause of postpartum mental health issues in mothers (Upadhyay et al., 2017). Socioeconomic status with lower and lower middle class families report most cases of postpartum issues in mothers in India (Arora & Aeri, 2019).

Beyond individual risk factors, the family structure and dynamics emerged as crucial contexts for postpartum depression. Lack of partner support was overwhelmingly recognized (76.9%), with lack of family support similarly prevalent (69.2%). Marital discord and living in nuclear family structures were identified by 53.8% and 46.2% respectively, while partner alcoholism (46.2%) and living in joint families (15.4%) represented additional family-related dimensions. The finding that nuclear family structures (46.2%) show higher association with postpartum depression than joint families (15.4%) challenges traditional assumptions about family support. While nuclear families offer greater autonomy and privacy, they may lack the practical support and childcare assistance that joint families can provide. However, healthcare professionals also acknowledged that joint family living can introduce its own stressors, including interference, criticism, and lack of agency for new mothers. Healthcare professionals also stressed that the relationship between family structure and maternal mental health outcomes is complex and multifaceted, with isolation appearing to represent a more significant risk factor than the interference inherent in joint family dynamics.

Lack of family support may stem from various reasons such as birth of female child when a boy was desired or birth of more children when the family is already going through financial constraints especially in lower socioeconomic conditions. It is important to note that reasons for postpartum depression can be one but is mostly an amalgamation of various factors. Approximately 70% of the respondents identified it as one of the reasons for postpartum depression in the present study. It is consistent with the previous studies which identified it as one of the probable causes (Chandran et al., 2002; Upadhyay et al., 2017).

The research further identified delivery-related and childbirth factors associated with postpartum depression. Unplanned pregnancy was recognized by 69.2% of healthcare professionals, while multiple pregnancies (twins, triplets) were noted by 38.5%. Cesarean delivery (30.8%) and normal vaginal delivery (15.4%) were also cited as delivery-related factors, though with lower frequency than unplanned pregnancy. These findings align with existing literature where obstetric factors including unplanned pregnancy (Arora & Aeri, 2019) have been documented as contributors to maternal mental health challenges.

When queried about the impact of cultural beliefs on postpartum depression recognition and treatment, 46.2% of healthcare professionals reported that cultural beliefs significantly hinder recognition and treatment, while 30.8% indicated that cultural beliefs somewhat influence these processes. Only 7.7% believed cultural beliefs have little to no impact. This distribution suggests that while cultural factors create substantial barriers, they are not insurmountable and can be addressed through education and awareness initiatives. Healthcare professionals noted that cultural resistance varies by educational level, urban versus rural settings, and generational attitudes, with younger, more educated families showing greater openness to mental health care. Respondents described how postpartum mental health symptoms are dismissed as temporary weakness, sometimes attributed to supernatural causes like evil spirits or black magic, stigmatized as insanity that brings shame to the family, and normalized as ‘natural’ struggles of motherhood that all women must endure silently. These perspectives align with policy gaps identified in comprehensive reviews, where The Mental Healthcare Act of 2017 and Pradhan Mantri Surakshit

Matritva Yojana, 2025 documentation fail to specifically address postpartum mental health (Ministry of Health and Family Welfare, 2025; THE MENTAL HEALTHCARE ACT, 2017), and the National Mental Health Policy does not extensively address postpartum depression or maternal mental health after childbirth as a primary focus (Central Mental Health Authority, 2017).

Regarding clinical prevalence and diagnosis, a striking 30.8% of healthcare professionals stated ‘No such data available’, revealing a fundamental gap in systematic screening, documentation, and data collection regarding postpartum mental health in the region. Nearly half of respondents (46.2%) estimated that 0-10% of women are suffering with postpartum depression, while 7.7% each estimated 10-20%, 40-50%, and 50-60% respectively. This strikingly low figure for the majority stands in stark contrast to global prevalence estimates of 15-25%, suggesting massive underdiagnosis rather than genuinely low prevalence (Upadhyay et al., 2017; Wang et al., 2021).

Barriers to effective management proved both multiple and overlapping. Notably, 46.2% of respondents selected ‘All of the above’ when asked about barriers, indicating that challenges are multifaceted and pervasive throughout the healthcare system. Lack of awareness among mothers (38.5%) emerged as a significant barrier, while availability of mental health professionals was cited by 30.8%, and fear of stigma by 30.8%. Additional barriers included high patient-to-provider ratios (7.7%), with no respondents identifying inadequate maternity leave policies as a barrier. These findings align with research indicating that beyond lack of awareness of postpartum depression by health professionals, there are issues that may be barriers to prompt recognition and management, and that in India, women who deliver at a health facility often stay for less than 48 hours after delivery, leaving little opportunity for health personnel to counsel mothers and families on signs and symptoms of postpartum depression (Rajeev et al., 2024).

The awareness crisis in maternal mental health proved particularly stark. When asked whether mothers were aware of mental health services in healthcare facilities, 53.8% of healthcare professionals responded ‘No’, while 38.5% stated ‘I don’t

know’, resulting in 92.3% of respondents confirming either a lack of maternal awareness or uncertainty about awareness levels. Only 4 respondents (7.7%) confirmed that mothers possessed such awareness. This devastatingly low figure constitutes an arraignment of health communication and patient education efforts. If mothers do not know that mental health services exist or are available to them, they cannot access them regardless of need.

Public awareness of postpartum depression was similarly limited. When asked about general public awareness of postpartum depression and its symptoms, 46.2% characterized the public as ‘Somewhat aware’, another 46.2% said ‘Not very aware’ and 7.7% reported the public was ‘Not at all aware’. Notably, no respondents believed the general public was ‘Very aware’. Help-seeking behavior reflected this awareness deficit. When asked about the percentage of mothers seeking professional help for postpartum depression, 69.2% of healthcare professionals estimated less than 10% seek help, 23.1% estimated 10-20%, and only 7.7% believed more than 20% seek professional assistance. This overwhelmingly low help-seeking rate represents a critical public health failure. The vast majority of women experiencing postpartum depression suffer in silence, without professional intervention, counseling, or treatment. Prior studies have documented patient, provider, and system-level barriers and facilitators to addressing postpartum depression, and the current results showed that women had lower literacy levels concerning depression-related treatments (Fonseca et al., 2015, 2017; Grissette et al., 2018).

When asked about beneficial support systems for postpartum depression management, extended family support emerged as the most valued (84.6%), followed closely by access to professional mental health services (76.9%). Community outreach programs involving ASHA workers were identified by 61.5%, while local peer support groups were noted by 46.2%. The finding that 84.6% endorsed extended family support underscores the continued importance of family networks in the Indian context. Grandmothers, aunts, sisters, and other female relatives can provide practical assistance with childcare and household tasks, emotional support and validation, traditional postpartum care practices, and advice based on their own experiences. However, such support cannot be assumed and may

carry its own complications. The recognition of ASHA workers (61.5%) reflects awareness of their potential role. These Accredited Social Health Activists serve as important connecting links between people and healthcare systems, particularly in rural areas, with potential to identify at-risk mothers, provide basic psychoeducation, facilitate referrals, and conduct follow-up; roles currently recognized as valuable but underutilized. Guidelines on Accredited Social Health Activists (ASHA) document focuses on their role in facilitating antenatal and postnatal care, but does not cover postpartum depression screening, identification, or management or referral pathways for maternal mental health issues (Ministry of Health and Family Welfare, 2005).

Regarding the relationship between educational level and postpartum depression prevalence, responses revealed nuanced perspectives. Exactly 30.8% believed similar prevalence exists across all educational levels, suggesting that mental health challenges transcend educational boundaries. Another 30.8% associated higher prevalence with no formal education, pointing to vulnerabilities related to limited health literacy, economic disadvantage, and reduced autonomy. An additional 23.1% identified primary education with higher prevalence, while 15.4% associated higher education with increased postpartum depression. This minority perspective that educated women face heightened vulnerability reflects important observations: educated women may face heightened expectations and pressures, experience career-motherhood conflicts, demonstrate greater awareness of mental health (leading to more reporting), and may suffer social isolation if educated but living in traditional joint family structures. These finding challenges simplistic and stereotypical assumptions that education is universally protective and highlights the need for tailored support across all educational demographics.

Healthcare provider roles in addressing postpartum depression revealed significant variations. The majority (76.9%) identified providing emotional support and referrals to mental health services as their role. A substantial proportion also identified identifying depressive thoughts (46.2%), therefore applying behavioral modification techniques (46.2%), or assisting with decision-making (46.2%), sometimes providing practical support through problem-solving (38.5%) as possible solutions. Concerning gaps emerged: 30.8% indicated their role limited to only

diagnosing the condition, while 15.4% stated they focus solely on physical health. These variations suggest inconsistent understanding of healthcare providers' responsibilities in comprehensive maternal mental health care which is consistent with the previous studies suggesting to develop targeted interventions and improve mental healthcare delivery at primary care facilities (Sangwan et al., 2024).

Regarding government initiatives addressing postpartum mental health, 53.8% of healthcare professionals reported that no such initiatives are currently being taken by the state government. This reflects that despite occupying a central role in child's development and the reproduction of human capital, mothers continue to experience structural and institutional gender disadvantages, including neglect of their mental health needs. While motherhood is socially valorized, her personal needs are systemically underrecognized. An additional 46.2% identified collaboration between hospitals, NGOs, and ASHA workers, while only 15.4% mentioned integrating mental health screening in routine visits. Specialized training for healthcare providers was identified by just 7.7%. This distribution reveals that systematic screening using validated tools such as remains exceptionally rare, despite representing a fundamental requirement for effective postpartum depression detection. It also underlines a graver issue of an asymmetry wherein women are expected to provide continuous emotional and physical care, while institutional care for mothers particularly psychological care remains inadequate.

Despite the existence of multiple government schemes and acts at national and state levels, healthcare professionals' responses reveal a critical gap: these policies and programs do not adequately address postpartum depression or maternal mental health after childbirth. The **Maternity Benefit Act, 1961** regulates the employment of women around childbirth, providing essential protections and benefits, including paid leave, nursing breaks, and prohibitions against dismissal due to maternity-related absence. The subsequent **Maternity Benefit (Amendment) Act, 2017** (The Maternity Benefit (Amendment) Act, 2017, 2017) extends paid maternity leave to a maximum of 26 weeks with additional leave for pregnancy-related sickness and medical complications. While these legislative measures ensure job protection and wage security during the critical postpartum period, they remain focused exclusively on employment rights and physical recovery, making no provisions for mental health

screening, identification, or treatment. Mothers with postpartum depression receive job protection and paid leave, but no availability of mental health support from the Government despite evidence that psychological wellbeing profoundly impacts their capacity to benefit from this leave or engage in effective parenting and self-care.

The Reference Manual for Implementation of **Mental Healthcare Act, 2017** for Caregivers is a comprehensive guide covering general mental health conditions, rights of persons with mental illness, and treatment guidelines. However, it contains no mention of postpartum depression, postpartum psychosis, perinatal mental health, or maternal mental health issues specifically. The document focuses on general mental illnesses such as schizophrenia, bipolar disorder, depression, anxiety, and substance use disorders, with no consideration of the unique biological, psychological, and social dimensions of depression occurring specifically in the postpartum period. Healthcare providers trained under this manual receive no guidance on how postpartum depression differs from general depression, what specific screening tools are appropriate for identifying maternal mental health problems, or how to manage pregnant and postpartum women with mental health conditions (Central Mental Health Authority, 2017).

The **Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA), 2016** (Maternal Health Division, 2016) is exclusively focused on antenatal (prenatal) care provision through monthly fixed-day clinics. It has provisions for delivering quality antenatal care services and screening for medical complications during pregnancy which is mostly focused on physical ailments such as anemia, gestational diabetes, hypertension, and infectious diseases. While the document mentions postpartum family planning counseling and postnatal care briefly in some sections, it does not address postpartum depression, postpartum anxiety or other mental health disorders, postpartum psychosis, maternal mental health screening or management, or the emotional wellbeing of mothers after delivery. The focus is entirely on maternal medical and obstetric care during pregnancy and delivery, not on mental health after childbirth. This represents a significant implementation gap: women receive comprehensive medical screening during pregnancy for complications but no mental

health screening for perinatal depression, yet the postpartum period is the window of maximum vulnerability for postpartum depression onset.

The **National Mental Health Policy (NMHP) of India was launched in 2014**, following a 2012 resolution by the World Health Organization (WHO). The policy is aligned with international frameworks such as the WHO's Mental Health Policy, Plan, and Program (2005) and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD, 2007). It was also supported by then contemporary Indian legislation, including the Rights of Persons with Disabilities Act (RPWD, 2016) and the Mental Healthcare Act (MHCA, 2017). Its goals are to promote mental health overall, prevent mental illnesses, enable recovery, and encourage destigmatization, desegregation, and socio-economic inclusion for persons with mental illness (PWMI). It aims to provide accessible, affordable, and quality health and social care to all within a rights-based framework. The NMHP generally addresses the needs of 'vulnerable populations' and includes the promotion of MH at the level of **Anganwadi centers**, which are crucial for maternal and child health in India. However, there are no specific programs for the mental health of mothers or postpartum depression (S. Gupta & Sagar, 2022).

The **Guidelines on Accredited Social Health Activists (Ministry of Health and Family Welfare, 2005)** document focuses extensively on the role, responsibilities, selection, training, and institutional arrangements for ASHA workers under the National Rural Health Mission. The guidelines cover ASHA roles counseling on pregnancy, safe delivery, breastfeeding, immunization, and contraception, antenatal and postnatal check-up facilitation, awareness of physical health and community get-together, care of pregnant women and children, and prevention of common infections. However, the document does not cover any kind of postpartum mental health symptoms or issues be it postpartum blues, postpartum depression or postpartum psychosis; screening, identification, or management. It should however, considering the current scenario should along with the aforementioned responsibilities also cover maternal mental health concerns after childbirth, emotional wellbeing or psychological support for mothers, recognition of postpartum mental health symptoms, referral pathways for maternal mental health issues. There should be proper organization of training on mental health support for

mothers by ASHAs. Given that ASHA workers serve as the primary link between communities and healthcare systems in rural areas and are uniquely positioned to identify at-risk mothers during regular home visits in the early postpartum period, the absence of postpartum mental health training represents a terrible loss of opportunity for early identification and intervention of mental health crisis in mothers, if any.

Further, the **Guidelines for Implementing District Level Mental Health Activities under the National Mental Health Program (NMHP) (Ministry of Health and Family Welfare, 2015)** provide overarching administrative and operational guidelines for district-level mental health services. The guidelines cover District Mental Health Program implementation structure, management of common mental disorders like substance abuse and the uncommon ones such as but not limited to psychosis, depression, neurosis, dementia. Outpatient and inpatient services, training of health professionals, community awareness activities, day care centers, and integration of mental health into primary healthcare are a part of the program. However, like the National Mental Health Policy, these guidelines do not specifically cover maternal mental health such as postpartum depression or perinatal mental health specifically. Care after childbirth, screening, identification, or management of postpartum depression, special considerations for mothers in the postpartum period, training for healthcare providers on postpartum mental health, or community awareness specific to maternal mental health are not incorporated in the same. The irony is stark: district mental health programs address depression broadly but make no specific provision for the woman most likely to experience depression - the newly delivered mother.

These above discussed **seven government schemes** collectively address maternal health broadly through employment protection, institutional delivery promotion, general mental health services, common mental health issues and community mobilization. Yet, none of them, individually or collectively, specifically mentions, acknowledges or mandates any guidelines for postpartum mental health screening, identification, clinical diagnosis, or treatment. While each scheme contributes something to the broader maternal healthcare ecosystem, none recognizes

postpartum depression as a distinct clinical issue requiring any specific, targeted interventions. The cumulative effect is that a mother experiencing postpartum depression may be employed under protections of the Maternity Benefit Act, may access physical postnatal care through other, may receive general mental health counseling under the Mental Healthcare Act if she actively seeks it, and may be contacted by ASHA workers for routine health updates if she is residing in rural areas yet nowhere in this entire ecosystem is there a systematic, coordinated process for identifying her depression, validating her concerns, examining the screening for severity, offering evidence-based treatment, or monitoring her recovery. She falls through the spaces between schemes, each of which addresses components of her care but none of which takes responsibility for her mental health in the postpartum period.

When asked about central government schemes impacting maternal mental health, respondents identified maternity leave policies (69.2%), the Pradhan Mantri Surakshit Matritva Abhiyan (61.5%), and community support programs involving ASHA workers and ANMs (53.8%). The National Mental Health Program was cited by 30.8%, the National Mental Health Care Act 2017 by 23.1%, and the District Mental Health Program by 15.4%. These findings indicate that while multiple schemes exist, their specific focus and effectiveness for postpartum mental health remain unclear even to the practitioners. Healthcare professionals recognize these programs as part of the broader maternal health landscape but lack clarity regarding how these schemes specifically address postpartum depression or whether they provide the tools and training necessary for implementation in their facility settings. Some of them even mentioned in the open-ended answers a concern for the lack of mental health provisions on paper and in practice. A couple of doctors even offered a simple yet unavailable solution of **counseling the needful mothers immediately after delivery** regardless.

Regarding the perceived effectiveness of state and local government initiatives, 84.6% rated existing efforts as ‘Somewhat effective’ while 7.7% each reported initiatives as either ‘Not effective’ or noted that no initiatives were in place. Notably, no respondent rated any initiative as ‘Very effective’ indicating consensus that

current efforts are insufficient in scope, reach, or quality to significantly impact maternal mental health outcomes. This perception aligns with the content analysis of policy documents: efforts exist but are not targeted to the specific problem of postpartum mental health.

The respondents were divided on whether postpartum depression is a ‘disease of modern civilization’ (Hahn-Holbrook & Haselton, 2014). Exactly 61.5% approve this perspective, possibly attributing increased prevalence to increased nuclear family structures and isolation, lack of partner support, breakdown of traditional support systems, still persisting specific gender preference, and decreased physical activity, adulterated food availability or altered lifestyles. Conversely, 38.5% rejected this characterization, potentially recognizing that postpartum depression has always existed but was undiagnosed and unnamed, superstitions and shame surrounding the issue and traditional societies also imposed tremendous pressures on mothers through gender preference and high fertility demands.

The long-term consequences of untreated postpartum mental health issues such as depression be severe and multifaceted. It can lead to relationship issues which in current study came to 76.9 percent. 53.8% noted impact on mother-child bonding and ongoing mental health challenges. Changes in parenting style were identified by 38.5%, with only 7.7% reporting no noticeable long-term effects. These findings highlight the tumbling consequences of untreated depression. Untreated depression can lead to persistent marital conflict and emotional distance, poor mother-child bonding with reduced maternal sensitivity and responsiveness, decreased breastfeeding success, developmental delays in children, evolution into chronic depressive disorders, anxiety disorders, increased risk of depression in subsequent pregnancies, and reduced overall quality of life for both mother and child (Nylen et al., 2006; Slomian et al., 2019).

Healthcare professionals provided important recommendations specifically for postpartum depression. Multiple respondents emphasized the importance of dedicated mental health infrastructure within maternal care settings, with suggestions for dedicated counseling rooms and mental health professionals in labor

and delivery areas for both partners. Family engagement was emphasized as critical, reflecting the findings regarding protective factors and suggesting that interventions must target families through family counseling, partner education programs, and community awareness. Healthcare provider sensitivity and training was repeatedly highlighted as necessary, pointing to the need for training in trauma-informed care, empathetic communication, and routine psychoeducation. Multiple providers emphasized the need for institutional investment through establishment of counseling centers at all tertiary care facilities.

The current study and its findings collectively reveal that postpartum depression in Rajasthan is not primarily a clinical problem compliant to purely medical solutions. Rather, it is a multifaceted public health challenge rooted in gender discrimination, lack of awareness, inadequate social support, cultural stigma and taboo, systemic healthcare failures, and policy implementation gaps. While numerous government schemes address components of maternal health, none of them address postpartum mental health specifically. Healthcare professionals recognize these dimensions but feel constrained by limited resources, inadequate training, overwhelming patient loads, and lack of institutional support for addressing mental health specifically in the postpartum period. Another important aspect to note is that even when the mother is literate and aware of the issue, there are very few or no resources available adjacent to her place of residence. What emerges powerfully is that healthcare professionals are not merely service providers they are potential change agents whose perspectives can inform more effective, contextually appropriate interventions. Their documented observations and recommendations offer a roadmap for transforming postpartum mental healthcare in Rajasthan, requiring coordinated action across multiple sectors including Government's interference, healthcare infrastructure development, general knowledge regarding the same to both patients as well as general physician, targeted provider training and sensitization in postpartum mental health, comprehensive integration of mental health screening in all postpartum care programs, family engagement strategies, community awareness campaigns, and most critically, modification of existing government schemes and creation of new targeted schemes exclusively for Depression along with accountability mechanisms to specifically address postpartum depression as a priority maternal health condition.

3.8. The Three-Tiered Implementation Gap

Tier 1: Policy Translation Gap

The most significant gap that exists during the translation phase - transforming national policy into operational guidelines at the state level. None of the current national policies on maternal health or mental health explicitly include postpartum mental health as a quantifiable outcome or an integral part of programmatic initiatives (Priyadarshini et al., 2023). The India Mental Health Observatory identified ‘monitoring’ as the ‘most neglected domain’ of NMHP implementation. In India only Tamil Nadu and Gujarat reported systematic monitoring mechanisms. Most states like Rajasthan lacks any systematic monitoring of its schemes (Priyadarshini et al., 2023). This highlights that even if there is integration of maternal mental health policy, the results are not guaranteed. Also, without any proper monitoring the policymakers cannot identify or justify resource.

Tier 2: Resource Allocation Gap

The burden of postpartum mental health is growing, but the country **lacks exclusive policies to address it**. Funding for mental health generally is allocated, but there is no specific mention of a budget solely for maternal mental health within the existing schemes and programs. For 2021–2022, the Indian government dedicated a total of **Rs. 5970 million** to mental health care out of which only **Rs. 400 million** was dedicated to the National Mental Health Program (NMHP). Most mental health funds supported two centrally controlled institutions: Rs. 5000 million to the National Institute of Mental Health and Sciences (NIMHANS) in Bangalore and to Lokpriya Gopinath Bordoloi Regional Institute of Mental Health in Tezpur, Rs. 570 million was allocated. Although the NMHP has been repeatedly revised, but still fails to incorporate maternal mental health (Priyadarshini et al., 2023).

The consequences of the lack of policies and dedicated resources for maternal mental health in India are significant which includes but is not limited to under-recognition and under-treatment of 14-24% prevalence of postpartum depression (Priyadarshini et al., 2023; Upadhyay et al., 2017); lack of inclusion in existing policies; primary focus on **Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH + A) Program**; unavailability or inferior treatment;

inadequate information about mental health, specifically maternal mental health and intergenerational impact on children (Priyadarshini et al., 2023).

In India, only Kerala and Gujarat had dedicated budget for mental health in their state budgets. Rajasthan, along with most states, allocates less than 1% of total health budget to mental health services. This creates a fiscal impossibility for integrating postpartum mental health services even where policy frameworks exist (Priyadarshini et al., 2023).

In certain states like Rajasthan, district-level programs report difficulty accessing centrally allocated funds due to cumbersome administrative procedures, leading to program delays and service gaps (Kirpekar et al., 2024).

Tier 3: Human Resource and Capacity Gap

India faces a severe psychiatrist shortage: 0.3 per 100,000 population nationally, with most states falling below the World Health Organization recommendation of 1 per one lakh patients. Rajasthan is among the most underserved states, with psychiatrists concentrated in urban areas like Jaipur (Kirpekar et al., 2024) and that too is unequipped with sufficient resources.

Auxiliary Nurse Midwife (ANM) and **Accredited Social Health Activist (ASHA)** are already overburdened with reproductive health service delivery, disease surveillance, and nutrition programs. Incorporating mental health screening without corresponding workload reduction or proper training and incentive and salary restructuring creates implementation resistance (Akkineni et al., 2025).

3.9. Policy Recommendations

- **Addressing the Stigma associated with postpartum mental health issue:**

Stigma is not an individual prejudice but a systemic, structural phenomenon deeply rooted in the health institutions therefore leading to a lack of any policy or scheme for mental health of women. This is a violation of women's rights. Absence of policy signals to women and communities that postpartum mental health is neither an issue nor a medical priority, especially in a country of billion mothers.

Therefore, there is a need for mental revolution not just for the common people but also the healthcare industry in India.

- **Timely implementation of programs**

A comprehensive case study of Rajasthan's maternal health (Iyengar et al., 2009) documented persistent implementation failures across multiple national programs despite policy existence (S. D. Iyengar et al., 2009).

The RCH (Reproductive Child Health)-1 programme (1997-2002) was not effectively implemented in Rajasthan until 1999-2000, creating years of policy-practice lag, indicating extremely slow implementation.

Rajasthan doesn't only need impactful and specific provision for mental health issue but also a timely implementation and continuous monitoring of the same.

- **Human Resource Alignment**

According to (S. D. Iyengar et al., 2009), 38% of ANMs did not stay in their designated subcenter villages despite residential facilities and first Referral Units remained non-operational due to specialist staff shortages in Rajasthan.

Strict Human Resource Alignment can ensure the crisis is not only addressed but also tackled in time. Postpartum depression ought to be treated as an immediate and urgent issue because lack of this sometimes has drastic consequences.

- **Smart Integration Strategy**

Rather than creating a separate maternal mental health program (which would be cumbersome and add to administrative burden) it could be integrated into any of the existing seven maternal health policies like in National Mental Health Policy or Pradhan Mantri Surakshit Matritva Abhiyaan among many.

Utilizing the ANMs and ASHA workers efficiently can also bring considerable difference as they know the ground reality of the situation.

- **Strengthening Monitoring and Accountability**

There must be a mandatory district-level reporting of postpartum mental health screening. States should establish baseline prevalence surveys in all the tertiary healthcare centers where hundreds of deliveries take place every single day. Technical support to under-resourced districts should be provided and knowledge sharing across high-performing and low-performing districts.

3.10. Conclusion

This study examined healthcare professionals' perspectives on postpartum mental health crisis in Rajasthan, revealing a critical gap between existing policy frameworks and the lived reality of maternal mental health in clinical practice. The research centered 52 healthcare professionals predominantly gynecologists (65.4%) from both government and private institutions - as primary data sources, capturing their systematic observations across thousands of deliveries and cases rather than relying on individual patient narratives. This methodological choice proved essential as a single gynecologist's observational experience encompasses hundreds to thousands of maternal cases annually, providing population-level insights unattainable through traditional patient-centered research alone which can generate in-depth response but also include personal bias.

The findings underscore that postpartum mental health in Rajasthan is fundamentally an amalgamation of personal, familial, clinical, cultural, systemic, and administrative challenges. Gender preference pressure and lack of partner support emerged as the dominant risk factors, each identified by 76.9% of respondents, reflecting deeply rooted gender discrimination embedded within Rajasthan's social fabric. Female child birth (69.2%), financial difficulties (69.2%), and past psychiatric history (69.2%) aggravated these vulnerabilities. Yet these individual risk factors exist within a broader ecosystem of family dysfunction - lack of partner support (76.9%), marital discord (53.8%), and nuclear family isolation (46.2%); that healthcare professionals recognized as amplifying maternal distress.

The research documented a profound awareness crisis within Rajasthan's healthcare system. When asked about maternal awareness of mental health services, 92.3% of

healthcare professionals reported mothers were either unaware or their awareness status was uncertain - with only 7.7% confirming maternal knowledge of available services. Moreover, 69.2% of professionals estimated fewer than 10% of mothers seek professional help for postpartum depression, representing massive underutilization of care despite obvious need. This awareness gap is not individual in nature - it persists regardless of provider experience - but structural: a systemic failure of health communication and patient education. Public awareness is similarly bleak, with no respondents believing the general public was 'very aware' of postpartum depression. The research thus identified and quantified what healthcare professionals have long observed clinically: the majority of women experiencing postpartum depression suffer in silence, isolated by stigma, lack of information, and absence of accessible services.

The study identified cultural beliefs as significant barriers to care, with 46.2% of healthcare professionals reporting that cultural beliefs significantly hinder postpartum depression recognition and treatment. Postpartum mental health symptoms are dismissed as temporary weakness, attributed to supernatural causes, stigmatized as family shame, and normalized as inevitable maternal suffering. This cultural barrier cannot be addressed through clinical innovation alone; it requires gender-transformative policy integrating violence prevention, women's educational and economic empowerment, and gender-aware healthcare provider training-components majorly absent from Rajasthan's postpartum mental health strategy.

Critically, the research documented that while multiple government schemes and acts exist on Central level- the Maternity Benefit Acts (1961 and 2017), Mental Healthcare Act 2017, Pradhan Mantri Surakshit Matritva Abhiyan, National Mental Health Policy, District Mental Health Programme guidelines, and ASHA worker guidelines - none specifically or adequately addresses postpartum depression as a distinct health issue. These seven schemes and programs collectively address maternal health broadly through employment protection, institutional delivery promotion, general mental health services, and community health activation, but none mandates or provides guidelines for postpartum mental health screening, identification, treatment or monitoring. The Maternity Benefit Acts ensure job

protection and paid leave but make no provisions for mental health support. The Janani Suraksha Yojana emphasizes physical postnatal care without mental health components. The Mental Healthcare Act 2017 provides general mental health rights but does not specifically recognize perinatal women as a priority population. The PMSMA focuses exclusively on antenatal care. Most devastatingly, the National Mental Health Policy fails to identify postpartum depression as a clinical priority despite it being the most common mental health condition affecting women in the postpartum period.

A mother experiencing postpartum depression therefore falls through the spaces between schemes as she receives employment protection but no mental health support, accesses physical postnatal care but no depression screening, and many rural women may be contacted by ASHA workers for routine updates but encounters no systematic identification of her psychological distress is done. Healthcare professionals recognized this implementation failure; 53.8% reported no state government initiatives for postpartum mental health, while 84.6% of those aware of initiatives rated them only ‘somewhat effective’. No respondent rated any initiative as ‘very effective’, which is concerning and alarming.

The research documented the long-term consequences of this systemic failure. Untreated postpartum depression resulted in relationship deterioration (76.9% of cases), impaired mother-child bonding (53.8%), ongoing maternal mental health challenges (53.8%), and parenting style changes (38.5%). These cascading consequences - from individual suffering to family dysfunction to developmental impacts on children - ultimately on Human Resource Development represent preventable public health failures.

What distinguishes this research is not the identification of existing problems, which prior studies has documented extensively and most effectively. Rather, the contribution lies in systematically capturing healthcare professionals' direct observations of these failures in real-time practice, their identification of where policy mandates exist but implementation falters, and their specific recommendations for bridging the gap. Healthcare professionals emphasized the

need for integrated mental health screening into existing postpartum care infrastructure rather than parallel programs; training of ASHA workers and ANMs in mental health assessment with corresponding workload and incentive restructuring; establishment of referral protocols from primary health centers to district mental health services; and dedication of institutional resources, counseling rooms, mental health professionals embedded within maternity services within existing healthcare facilities.

From a public administration perspective, Rajasthan's postpartum mental health challenge is fundamentally a governance challenge. It reflects not only policy deficiency but structural misalignment: fragmented administrative structures separating reproductive health from mental health pathways, inadequate budget transfers despite stated policy priorities, insufficient human resource investment to support screening and intervention at scale, weak monitoring mechanisms that render postpartum mental health invisible in data and accountability systems, and intersectional inequalities.

The findings collectively establish that closing the policy-implementation gap in Rajasthan requires neither new policies nor additional programs layered atop an already fragmented system. Rather, it demands deliberate administrative integration of mental health components into existing infrastructure, accompanied by accountability mechanisms and political commitment. Such integration requires amending existing guidelines to include postpartum depression screening using standardized tools at postnatal visits; establishing clear referral protocols; redefining healthcare worker roles with explicit mental health responsibilities and corresponding incentive restructuring; ensuring state-level coordination through the recently established Rajasthan State Mental Health Authority to maintain minimum service standards, monitor equity, and facilitate knowledge sharing across districts; and establishing systematic monitoring of screening coverage, treatment linkage, and outcomes.

Decentralization should not mean fragmentation. While district-level flexibility in implementation is necessary given Rajasthan's diverse geography and capacity -

from urban centers like Jaipur and Kota to the resource-scarce tribal districts of southern Rajasthan - state-level coordination mechanisms must ensure proportional resource allocation to underserved areas, technical support to low-performing districts, and regular monitoring of equity and outcomes. The India Mental Health Observatory has documented that monitoring represents the "most neglected domain" of implementation; Rajasthan must establish baseline prevalence surveys, particularly in tribal areas where data is sparse, and mandate district-level reporting of screening coverage, treatment completion, and referral outcomes.

The research demonstrates that healthcare professionals are not merely clinical service providers but potential change agents whose systematic observations and recommendations offer a blueprint for transformation. Their findings - that 76.9% of postpartum mothers lack partner support, that 92.3% remain unaware of available mental health services, that 69.2% of those with depression seek no professional help - constitute evidence for why existing government efforts, while well-intentioned, have failed to address this critical public health challenge. The study thus provides the evidence base necessary to justify policy modification, resource reallocation, and administrative reform to integrate postpartum mental health into Rajasthan's healthcare system - transforming what currently remains a hidden, unaddressed burden into a visible, measurable, and addressable priority within the broader maternal health agenda.

The postpartum mental health gap in Rajasthan is an example of public administration's central challenge: the persistent distance between policy aspiration and implementation reality. Yet, on the ground, most women experiencing postpartum mental health conditions remain invisible to these policies.

This gap emerges not only from policy deficiency but from structural misalignment across administrative systems - fragmented governance, inadequate budget transfers, absent or improper human resource investment, weak monitoring, and unrecorded mental health crisis in postpartum mothers. Stitching the gap efficiently requires not only fresh policies but deliberate administrative integration, accountability mechanisms, and political commitment to maternal mental health as a core maternal health issue.

From a public administration perspective, Rajasthan's maternal mental health challenge is fundamentally a governance challenge: integrating, maternal mental health policy into existing policies; it into coordinated implementation across all the districts, training required health workers, establishing referral networks, and monitoring outcomes and competing health priorities. Solving this requires administrative reform as much as clinical innovation.

Chapter 4

***Education of
Divyang Women***

CHAPTER 4

EDUCATION OF DIVYANG WOMEN

The Objective of this chapter is to find the probable reasons for the decline of enrollment of Female PwD category students in Higher Education (AISHE Report) in the state of Rajasthan. The information is gathered from the special educators and educators involved with the Divyang students.

This chapter is divided **into three sections**.

The **First section** provides an **Introduction** to the chapter with **Definition of Divyang, Types of Disabilities and the Existing Policies**.

The **Second section** discusses the following in detail:

- **Research Methodology**
 - **Research Design and Approach**
 - **Participants and Sampling**
 - **Data Collection**
 - **Data Analysis**
 - **Ethical Considerations**
- **Results**
- **Summary of the key findings**

The **Third section** discusses the following in detail:

- **Discussion**
- **Policy Recommendations**
- **Conclusion**

I

4.1. Introduction

4.1.1. Definition of Divyang

According to the Ministry of Social Justice and Empowerment, the term 'Divyang' refers to people with impairments, who are also known as "differently abled" in policy terminology. The Ministry uses 'Divyangjan' as a polite name for people with disabilities, emphasising their abilities rather than their limitations.

The term 'Divyang' was first officially mentioned in a government document during the 2016 Railway Budget address. On December 3, 2015, Prime Minister Narendra Modi initially proposed the term 'Divyang' (meaning "divine body") as a substitute for 'viklang' (disabled) during the launch of the Accessible India Campaign, subsequently reiterating this suggestion in his 'Mann Ki Baat' radio speech on December 27, 2015 (Ministry of Home Affairs, 2025).

It was coined to promote respect, dignity, and appreciation of potential in differently abled individuals. Government policies emphasise that disability should be viewed as an aspect of human diversity and a social issue, rather than a medical problem.

Having defined the terminology 'Divyang', next section discusses the types of Disabilities that has been identified by the **Rights of Persons with Disabilities (RPwD) Act, 2016**. This legislative action was taken by the Indian Parliament to align the country's laws with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD); increasing the number from seven to 21, almost triple in the year 2016.

4.1.2. Types of Disabilities

Under the Rights of Persons with Disabilities Act, 2016, India recognizes 21 categories of disabilities. These include (Press Information Bureau, 2016)

- Blindness
- Low vision
- Leprosy cured
- Hearing impairment

- Locomotor disability
- Dwarfism
- Intellectual disability
- Mental illness
- Autism spectrum disorder
- Cerebral palsy
- Muscular dystrophy
- Chronic neurological conditions
- Specific learning disabilities
- Multiple sclerosis
- Speech and language disability
- Thalassemia
- Hemophilia
- Sickle cell disease
- Multiple disabilities, including deaf-blindness
- Acid attack victim
- Parkinson's disease.

With the types of disabilities enlisted, the next sections provide a brief understanding of Department responsible for the Empowerment of such people and various educational measures taken to ensure the same.

4.2. Department of Empowerment of Persons with Disabilities (DEPwD)

The Department of Empowerment of Persons with Disabilities (DEPwD) is a government agency in India that works under the Ministry of Social Justice and Empowerment. It is committed to advancing the rights, well-being, and empowerment of people with disabilities (PWDs), also known as Divyangjan. DEPwD is in charge of developing and executing policies, programs, and initiatives to promote inclusion, accessibility, and equal opportunities for people with disabilities across the country. The department's mandate comprises a variety of areas such as education, employment, social security, accessibility, and rehabilitation to guarantee that people with disabilities can fully engage in societal, economic, and cultural activities.

4.3. Education for Divyangjan

The 2011 Census of India reports that there are 2.68 crore persons with disabilities, which is about 2.21% of the total Indian population, compared to a global average of 15%. The literacy rate among people with disabilities (Divyangjan) is approximately 55%, with male literacy at 62% and female literacy at 45%. However, only about 5% Divyangjan have achieved education at the graduate level or higher. Employment rates among this population further down the lane, with 36% employed overall, 47% of males employed, and only 23% of females in employment.

Various legislative measures have been upheld to protect and empower the Divyang, including the Rehabilitation Council of India Act (1992), the National Trust Act (1999), the Rights of Persons with Disabilities (RPwD) Act (2016), and the Mental Healthcare Act (2017). The first three are under the Ministry of Social Justice and Empowerment, while the Mental Healthcare Act is under the Ministry of Health and Family Welfare.

Education plays a critical role in improving the lives of everyone and persons with disabilities are no exception. It also includes the socialization of children with disabilities who often face marginalization. Despite all the schemes/policies and programs, the educational index for children with disabilities remains low compared to the general population. Programmatic efforts such as the Sarva Shiksha Abhiyan (SSA) launched in 2001 have also attempted to provide uninterrupted, quality education with inclusive policies, including a zero-rejection approach for children with special needs.

The RPwD Act, 2016 aligns with the spirit of the United Nations Convention on the Rights of Persons with Disabilities and mandates that children with benchmark disabilities have access to free education up to 18 years of age, either in special schools or inclusive neighborhood schools.

Further the National Education Policy (NEP) 2020 and initiatives like Sugamya Bharat Abhiyaan play critical roles in reinforcing inclusive education and accessibility.

Despite these extensive policy efforts and programs, admission rates for females in higher education in Rajasthan has continuously declined between 2017-2022 (Ministry of Education, 2019, 2020, 2021; Ministry of Human Resource Development, 2017, 2017), highlighting persistent challenges in educational inclusion for females with disabilities in Rajasthan. It was reported in the AISHE Report.

Since 2010-11, the Ministry of Education has conducted an annual web-based All India Survey on Higher Education (AISHE) to depict the country's higher education situation. The survey covers all institutions in the country that provide higher education. Data is being collected on a variety of parameters, including teachers, student enrolment, programs, examination outcomes, education financing, and infrastructure. The data acquired by AISHE is also be used to calculate indicators of educational development such as institution density, gross enrolment ratio, pupil-teacher ratio, gender parity index, and per student expenditure.

Government of India has taken various measures over the years to ensure equality and empowerment of Divyangjan. The following section provides a brief overview of four such landmark initiatives.

4.4. Existing Policies

4.4.1. Sugamya Bharat Abhiyaan (Accessible India Campaign) (2015)

Sugamya Bharat Abhiyan, or the Accessible India Campaign, aims to make the country barrier-free for persons with disabilities (PwDs). The Campaign focuses on accessibility across three pillars - built environment, transportation, and information & communication. The goal is to create an obstacle free environment in public buildings such as schools, hospitals, and government offices through ramps, accessible toilets, lifts, and tactile paths. The campaign also promotes accessible public transportation by improving facilities in buses, railways, and airports, and ensures that information and digital spaces are inclusive by adopting globally recognized accessibility standards, providing sign language, and increasing the number of trained interpreters.

Beyond improving physical and digital access, the campaign promotes inclusivity, equality, and independence for PwDs while benefiting society altogether. It includes senior citizens and parents with small children. It supports economic participation, awareness, and sensitivity toward disability issues, fulfilling legal obligations under the Rights of Persons with Disabilities Act, 2016.

4.4.2. Rights of People with Disabilities Act, 2016

(Ministry of Law and Justice, 2016)

The Rights of Persons with Disabilities Act of 2016 was enacted to implement the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), which was adopted by the UN General Assembly on December 13, 2006. The Convention emphasises equality, dignity, and empowerment for people with disabilities, as well as the idea of gender equality and other essential values.

Rights and Entitlements

According to Chapter II of the Act, the government and local authorities must ensure that women and children with disabilities have same rights as others. They must also provide chances for children with disabilities to openly express their opinions on all issues that impact them, with appropriate support based on their age and kind of disability.

Social Security, Healthcare, and Rehabilitation

Chapter V requires assistance for women with impairments in earning a living and raising their children. It also assures that disabled women have access to healthcare, particularly sexual and reproductive health services. The Act mandates special schemes for individuals with benchmark disabilities, including a 5% reservation for women with disabilities in agricultural land and housing allotment and poverty alleviation and development programs.

Governments are also expected to provide rehabilitation services and programmes within their economic means, particularly in the health, education, and employment sectors.

Education and Training

In higher education, all government and government-aided institutions must reserve at least 5% of places for people with benchmark disabilities. Furthermore, these students are eligible for a five-year waiver of the maximum age limit for admission. The Act also provides for free schooling in an appropriate environment for all children with qualifying disabilities until the age of eighteen.

Definitions and Principles

The Act defines "high support" as intensive physical, psychological, or other assistance necessary for people with benchmark impairments for daily activities, independent decision-making, and involvement in all aspects of life, such as education, employment, and community engagement. "Inclusive education" refers to a system in which students with and without disabilities learn together using teaching methods tailored to varied learning requirements. "Information and communication technology" refers to all digital, electronic, web-based, print, and telecom services that promote communication and access to information.

Measures for Inclusive Education

To encourage inclusive education, the government and local authorities should conduct surveys every five years to identify children with disabilities, assess their special requirements, and ensure their needs are satisfied.

- Survey must be conducted within two years of the Act's inception.
- Establish appropriate teacher training institutions.
- Provide training and employment opportunities for instructors with disabilities who are adept in sign language and Braille, as well as those who specialise in teaching children with intellectual disabilities.
- Train professionals and personnel to promote inclusive education at all levels.
- Establish sufficient resource centres to support educational institutions.
- Encourage individuals with speech or language challenges to use alternate ways of communication, such as Braille, sign language, and augmentative technologies, to fully participate in society and communicate successfully.

4.4.3. Measures taken by the Ministry of Education (Rajya Sabha, 2025a)

Shri K.R. Suresh Reddy asked a question in the Rajya Sabha about the steps taken by the Indian government to ensure that digital education programs are readily available to differently-abled students, the current state of status of assistive technologies for online learning in schools and colleges, whether there are plans to expand these initiatives for full inclusivity, and other details.

The Government of India has introduced a comprehensive set of measures to make digital education accessible for differently-abled students. Regulatory frameworks, guidelines, and special features have been deployed across platforms like DIKSHA, which has a dedicated section for Children with Special Needs offering a range of Universal Design for Learning (UDL)-based e-content - such as audiobooks, Indian Sign Language (ISL) videos, guides, and an ISL dictionary. The platform is also equipped with an accessibility plugin allowing customization of text size, contrast, and reader compatibility. Initiatives like NCERT's "Teaching Learning Interventions for Inclusive Classrooms" series with mandatory ISL interpretation, SWAYAM MOOCs supporting audio-visual content, and the E-PG Pathshala with over 23,000 accessible postgraduate resources further support inclusivity. Additionally, UGC regulations now mandate scholarships, fee waivers, learner support centres, and quality standards for disabled learners in higher education.

To expand and strengthen these initiatives, the government has introduced the 2020 AICTE guidelines requiring technical institutions to provide materials in accessible formats like large print, braille, tactile graphics, and digital reading devices. The National Education Policy (NEP) 2020 emphasizes assistive devices, accessible technology, and teaching materials in formats suitable for children with disabilities; these expectations are embedded in the National Curriculum Frameworks of 2022 and 2023. Implementation varies across institutions, but the government's ongoing commitment aims at steadily progressing towards full inclusivity - seen as a continuous process supported by policy, technology, and institutional mechanisms.

4.5. National Education Policy, 2020

(Ministry of Human Resource Development, 2020)

The National Education Policy (NEP) 2020 is consistent with the global education development goal SDG4 of the 2030 goal for Sustainable Development, which India endorsed in 2015, and intends to "ensure inclusive and equitable quality education and promote lifelong learning opportunities for all" by 2030.

The policy specifically prioritises the inclusion and equal participation of children with disabilities in early childhood education and care (ECCE) and the educational system, allowing them to fully participate from the foundational stages through higher education. It supports the Rights of Persons with Disabilities (RPWD) Act 2016's concept of inclusive education as a system in which students with and without disabilities learn together, with teaching and learning tailored to the learning needs of varied disabilities. There is a decline in the enrolment of female differently-abled students all over India, Rajasthan being one of the worst.

Recognising the decline in enrolment of differently abled children, particularly female students, the NEP recommends strengthening and modernising communities and educational institutions, such as schools, colleges, universities, and public libraries, to ensure an adequate supply of accessible, affordable books and educational software. All software will be written in major Indian languages and designed to be usable by kids in remote places and Divyang students. Teaching-learning e-content will be created in regional languages and distributed through platforms such as DIKSHA, which will also be expanded to support teacher professional development. The policy emphasises the integration of technology platforms (DIKSHA, SWAYAM) in schools and higher education, as well as user feedback systems for content enhancement.

NEP 2020 also recognises the need for more special educators who are knowledgeable in both subjects and understand the needs of children with disabilities. It presents short- and long-term training courses for pre-service and in-service teachers, available as certificates, full-time, part-time, and blended courses, and frequently held in multidisciplinary settings. The strategy asks for collaboration

between National Council for Teacher Education (NCTE) course curricula and the Rehabilitation Council of India (RCI) to ensure an adequate supply of competent special educators who can teach subjects to children with disabilities. Overall, the NEP emphasises developing enabling mechanisms to ensure that children with special needs have fair access to quality education on par with other children.

II

4.6. Research Methodology

4.6.1. Research Design and Approach

This study has a descriptive, exploratory, and mixed (qualitative and quantitative) research design. This approach was selected to systematically analyze the attitudinal, economic, physical, societal, and safety barriers that has led to decline in enrolment rate of divyang female in Higher Education in Rajasthan. The quantitative method provided numerical frequencies, percentages that illustrated the prevalence of barriers as perceived by educators working directly with differently-abled students (female).

Research Question

What are the views of Special Educators on declining rate of enrollment of female differently abled students in Higher Education in the state of Rajasthan for the past 5 years (as presented by the AISHE Reports) and what are various barriers and issues Divyang female students face, according to special educators in Jaipur and Kota Districts of Rajasthan?

4.6.2. Participants and Sampling

Population

The target population comprised special educators and teachers engaged in education of differently abled students in the higher education levels in Rajasthan. Special Educators were purposefully selected from both Government and the Non-Governmental Organizations of Rajasthan (Jaipur and Kota Districts).

Sampling Strategy and Participant Selection

A purposive (non-probability) sampling method was done. Participants were selected based on: (1) active employment in special/inclusive education settings, (2) geographic location in Jaipur or Kota, (3) formal qualifications in special education or teaching experience with differently-abled students, and (4) willingness to participate.

Educators were specifically chosen because they are the ones who interact with both students and their guardian, becoming the connecting link between the system and family of special students.

Sample Composition

A total of 40 educators participated: Jaipur (n=22, 55%) and Kota (n=18, 45%).

The sample comprised 65% female (n=26) and 35% male (n=14) educators; 60% (n=24) had 2-5 years of teaching experience; 65% (n=26) held Special B.Ed. qualifications; and 55% (n=22) worked in NGO/Special Education Centers.

Prior to questionnaire finalization, semi-structured interviews were conducted with 5 educators to identify primary barriers.

Locale of the study

According to the Census of 2011 Census, Kota was the most literate district in Rajasthan, with a literacy rate of 76.56% followed by Jaipur with a literacy rate of 75.51% (Directorate of Census Operations, 2011). Since most of the major facilities and institutions are available in these two educational hub districts of the study, these were best suited for the study. These two districts host students not only native to the city but from the entire Rajasthan presenting a holistic picture of the situation. Hence the decline in enrolment of overall Rajasthan can be understood by deeply interrogating these two microcosms of Rajasthan.

4.6.3. Data Collection

Google Form was distributed via mail and WhatsApp and Personal visits were used as instruments to collect data.

A structured questionnaire with closed-ended multiple-choice items was designed consisting of the following-

- Demographic information (age, gender, qualification, experience, institution type, location)
- Economic barriers (transportation, equipment costs, hostel facilities, school fees)
- Physical barriers (infrastructure accessibility, trained teachers, school proximity, rural school availability)
- Attitudinal barriers (family sympathy, social shame, lack of support, safety concerns)
- Societal barriers (gender preference, orthodox beliefs, community support)
- Safety concerns (transport inadequacy, harassment vulnerability, hostel insecurity, lack of female staff)
- Policy awareness and implementation perceptions
- Perspectives on NEP 2020 inclusive education
- Reasons for declining higher education enrollment

(The questionnaire was administered in English and Hindi to ensure accessibility.)

Data collection occurred in three stages -

Pilot Stage: Semi-structured interviews with 5 special educators to identify thematic barriers and refine questionnaire design.

Administration Stage: Questionnaires distributed via two methods for maximum accessibility: (a) digital Google Forms distributed via email/WhatsApp, and (b) in-person administration at institutions in Jaipur and Kota.

Consolidation Stage: All responses (digital and paper) were compiled into a unified dataset.

Data Integration

National higher education enrollment statistics for female students with disabilities in Rajasthan were sourced from the All-India Survey on Higher Education (AISHE) Report (2017-18 to 2021-22) to examine.

4.6.4. Data Analysis

Data Preparation

Survey responses were systematically entered into spreadsheets using Microsoft Excel. For items where respondents could select multiple options, each barrier was recorded as a binary indicator (selected/not selected), to understand the independent analysis of each barrier's frequency and regional prevalence. All 40 questionnaires met completion criteria and were retained for analysis.

Analysis Methods

Descriptive Statistics: Frequencies and percentages were calculated for all barrier categories; some were organized by type while others by geographic location (Jaipur vs. Kota) to document prevalence and enable regional comparison.

Rationale and Justification

A quantitative survey design was optimal for addressing the research question of identifying and comparing multiple barrier types across the data. Mixed data collection methods (digital and in-person) balanced convenience and personal interaction. Pilot interviews ensured that survey items reflected local context and educator language, maximizing validity and relevance.

Primary data collection was conducted over six months duration, spanning November 2024 to May 2025, across Jaipur and Kota districts.

4.6.5. Ethical Considerations

Informed Consent: All participants received written information about study aims, procedures, confidentiality, and voluntary participation.

Confidentiality and Anonymity: Data were stored securely with access restricted to the researcher only. Providing names was completely optional. Even then, it was nowhere used in the research.

After collecting the Data and analyzing it in detail, following results were obtained from the descriptive study.

4.7. Results

4.7.1. Demographic Characteristics of Respondents

A total of 40 respondents which included special educators with special and regular B.Ed. participated. A questionnaire was framed on the basis of open-ended interviews from 5 special educators.

Table 4.1: Demography of the Educators			
Characteristic	Category	N=40	%
Gender	Female	26	65.0
	Male	14	35.0
Age Group	Below 25	06	15.0
	25-35	14	35.0
	36-45	10	25.0
	46-55	8	20.0
	Above 55	2	5.0
Educational Qualification	General B.Ed.	4	10.0
	Special B.Ed.	26	65.0
	Masters/Diploma in Special Ed.	08	20.0
	Master of Occupational Therapy	2	5.0
Teaching Experience	<2 years	4	10.0
	2-5 years	24	60.0
	6-10 years	4	10.0
	11-15 years	2	5.0
	>15 years	6	15.0
Institution Type	Private (Exclusive)	16	40.0
	NGO/Special Education Center	22	55.0
	Government School (Inclusive)	2	5.0
Primary Teaching Location	Jaipur	22	55.0
	Kota	18	45.0

Table 4.1 indicates a predominantly female workforce, with women constituting 65 percent of the sample. Majority of the respondents fall within the 25–35 years age group (35%), followed by those aged 36–45 years (25%), reflecting a relatively young to mid-career teaching population. In terms of qualifications, a significant number of respondents hold a Special B.Ed. degree (65%), suggesting that most educators possess specialized training which is relevant to the field and

understanding of differently abled female. With respect to teaching experience, 60 percent have been in the profession for 2–5 years, indicating a strong connectedness with moderate practical exposure. The sample is largely drawn from NGO-run or special education centres (55%), while 40 percent work in private exclusive institutions, and a very small fraction (5%) are from government-inclusive settings (because special educators are hired on temporary basis only). Geographically, the educators is fairly distributed between Jaipur (55%) and Kota (45%), ensuring representation from both locations and ensuring comparative study.

The Primary data was collected via group Discussions, Personal Interviews and Questionnaire which is thematically discussed below.

4.7.2. Barriers to Education

a) Economic Barrier

Following is an analysis of the economic barrier faced by girls with disabilities in accessing education; a comparison between Jaipur and Kota districts.

Table 4.2: Economic Barriers to Education of Differently abled Female (Respondents can choose more than one option)		
Probable Reasons	Jaipur (N=22)	Kota (N=18)
Lack of transportation facilities	18 (82%)	16(89%)
High costs of disability-related equipment	16(73%)	10(56%)
Lack of safe hostels for female differently-abled students	16(73%)	18(100%)
School fees for special schools	18(82%)	10(56%)

Table 4.2. represents 82% of respondents in Jaipur and 89% in Kota have cited transportation issues, indicating widespread concern in both districts. The most striking reason as unanimously said by all the respondents of Kota is the lack of safe hostels for female differently-abled students; 100%. Large percentage of educators report high expenses for disability-related equipment (73% in Jaipur and 56% in Kota) and special school fees (private) (82% in Jaipur and 56% in Kota), indicating significant economic constraints in both regions.

b) Attitudinal Barriers

The following section analyses how the family and societal attitudes impact the education of Divyang girls in Jaipur and Kota.

Table 4.3: Attitudinal Barriers to the Education of Divyang Female (Respondents can choose more than one option)		
Probable Reasons	Jaipur (N= 22)	Kota (N= 18)
Families show excessive sympathy, undermining confidence.	16 (73%)	2(11%)
Families feel shame in taking differently-abled children out in public, hindering their social skills	16 (73%)	32(89%)
Society does not provide strong support for the education of disabled girls	18(45%)	28(100%)
Families are overly concerned about the safety of their female child, especially if she is differently abled.	14(82%)	32(78%)

Table 4.3. shows that societal and familial attitude significantly affect the education of differently abled female in the state of Rajasthan, specifically Jaipur and Kota districts. While 73% of families in Jaipur exhibit excessive sympathy, which undermines confidence, this figure is substantially lower at 11% in Kota. In contrast, 89% of Kota residents feel ashamed about taking differently-abled children out in public, compared to 73% in Jaipur, showing a deeper societal stigma.

Notably, 100% of respondents in Kota indicate a lack of strong societal support for disabled girls' education, a complete unanimity, whereas just 45% in Jaipur believe this.

Respondents were given a free option as 'Other' to fill any additional reasons. One additional attitudinal barrier is that Families live in denial for a very long time and keep sending their children with special needs to inclusive setting where they develop inferiority complex and don't learn anything.

c) Societal Barriers

Societal issues that contribute most to the under-education of Divyang girls' education. *(Respondents can choose more than one option)*

Table 4.4: Societal Barriers to the Education of Divyang Female (Respondents can choose more than one option)		
Probable Reasons	Jaipur (N=22)	Kota (N=18)
Gender preference for educating boys	16 (73%)	10(56%)
Orthodox beliefs about the purpose of educating a girl child, which are amplified when it comes to females with disabilities	18(82%)	16(89%)
Lack of community support systems for disabled individuals	10(45%)	12(67%)

Table 4.4. represents the societal barriers that may hinder the educational opportunities to female Divyang students in Rajasthan. The orthodox attitudes regarding the purpose of education for females - particularly for girls with disabilities - are a major socio-cultural barrier in both districts, with 82% reporting it in Jaipur and 89% in Kota. Gender preferences for males' education are extremely prevalent, particularly in Jaipur (73%), demonstrating a major cultural barrier still prevalent in society. Furthermore, the absence of community support structures is particularly noticeable in Kota, where 67% of respondents consider it a barrier, compared to 45% in Jaipur.

Respondents were given a free option as 'Other' to fill any additional reasons. One additional societal barrier is that people believe that there is no benefit of teaching these kids; they treat them as a burden. Additionally, they fear that despite education they won't be able to compete with regular children and thus viewing education as unnecessary and optional.

d) Physical barriers

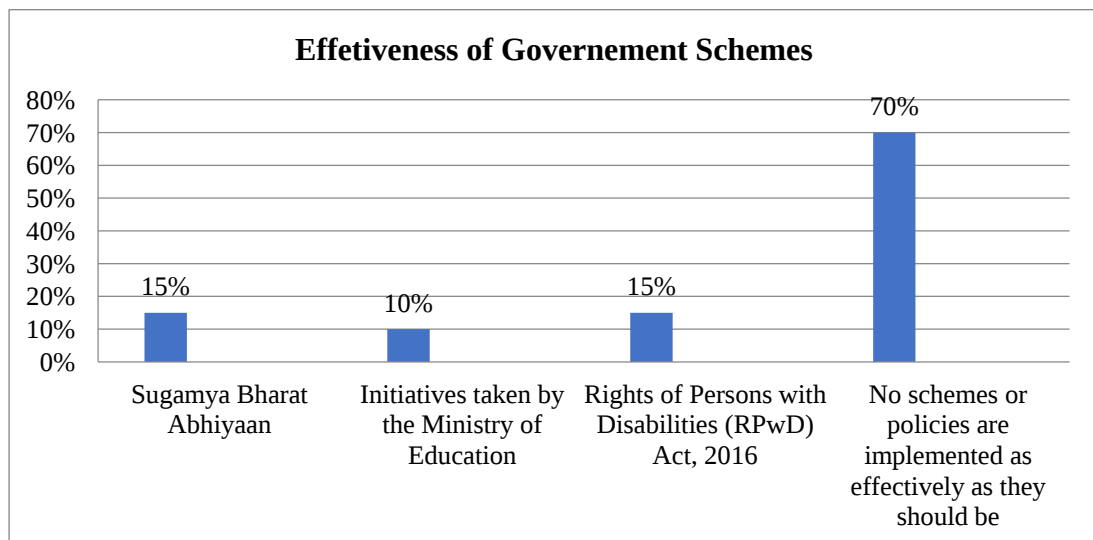
Following are the probable physical barriers preventing enrolment of Divyang girls school in Jaipur and Kota.

Table 4.5: Physical Barriers to the Education of Divyang Female (Respondents can choose more than one option)		
Reasons	Jaipur (N=22)	Kota (N=18)
Inaccessible school infrastructure	12(55%)	12(67%)
Lack of trained teachers	10(45%)	8(44%)
Proximity of schools to their homes	10(45%)	12(67%)
Absence of schools for differently-abled students in rural areas	20 (91%)	14(78%)

In Table 4.5. The most noticeable Physical Barriers in both districts is the lack of schools for differently abled in rural regions, which was observed by 91% of Jaipur respondents and 78% in Kota, thus limiting the enrolment. Infrastructure concerns are also prevalent, with 55% of Jaipur residents reporting inaccessible school buildings and 67% in Kota. Furthermore, school proximity is a greater worry in Kota (67%) than in Jaipur (45%), yet a lack of trained instructors is mentioned at comparable percentages in both districts.

4.7.3. Policy Awareness & Implementation

When asked about government schemes that are effective and policy implementation for female Divyang students' education, following was the response of the educators (N=40).

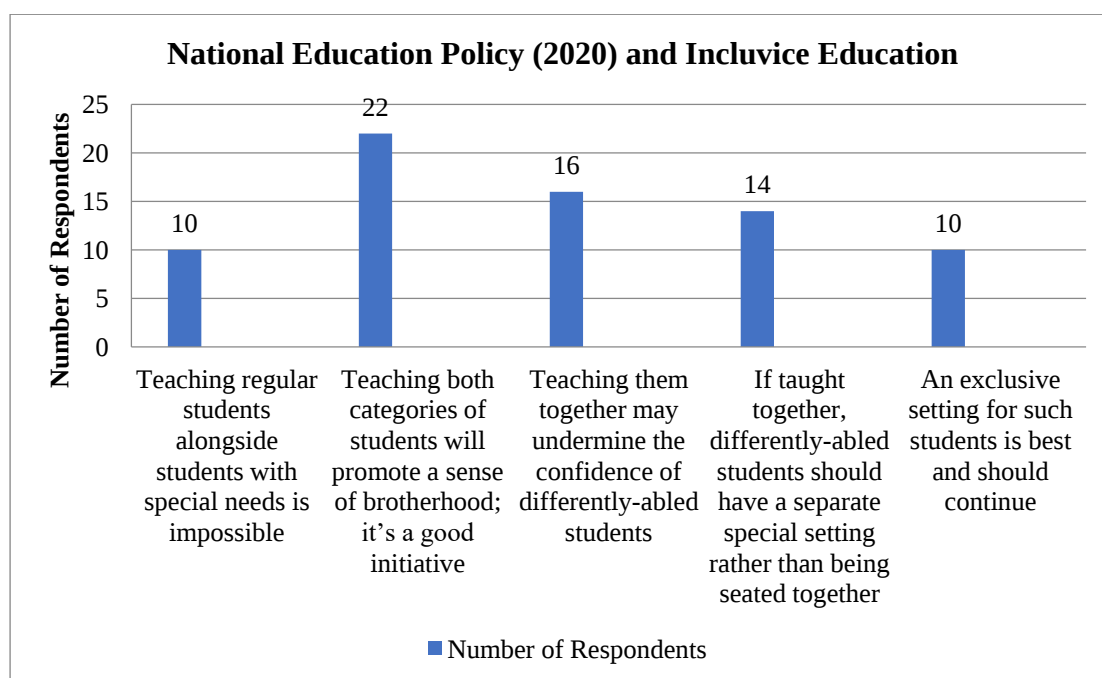


Source: Primary data

Figure 4.1: Perceived Effectiveness of Policies and Schemes: Educators' Perspectives (Respondents can choose more than one option)

As represented in Figure 4.1., the majority of educators (70%, n=28) experienced that no schemes or policies are implemented as effectively as they should be, while only 10% (n=4) acknowledged initiatives taken by the Ministry of Education, with the remaining responses distributed between awareness of the RPwD Act, 2016 (15%, n=6) and Sugamya Bharat Abhiyaan (15%, n=6), collectively indicating a significant policy-implementation gap at the grassroots level.

Following section discusses the response of educators on the effectiveness of National Education Policy of 2020. **Figure 4.2.** demonstrates the responses on the question of National Education policy of 2020 and Inclusive Education.



Source: Primary data

Figure 4.2: Vertical Bar Graph on opinions of Respondents on the National Education Policy (NEP) 2020 and Inclusive Education

As demonstrated in the Figure 4.2., 55% of respondents (n=22) agreed that 'teaching both categories of students will promote a sense of brotherhood', but substantial reservations remain: 40% (n=16) felt that inclusive classrooms may undermine the confidence of differently-abled students; 35% (n=14) preferred a separate special setting even if taught together; 30% (n=12) supported continuing exclusive settings for such students; and 25% (n=10) considered inclusive teaching 'impossible'; an option of 'Other' was left blank for any additional response and a very small

number (5%, n=2) advocated special classes for difficult topics, reflecting the diversity of perspectives and concerns about one-size-fits-all inclusion.

4.7.4. Declining rate of enrolment in Higher Education in Rajasthan of female students (AISHE Reports)

According to the *All-India Survey on Higher Education (AISHE) Report*, the enrolment of female PwD students in higher education has been consistently declining in Rajasthan.

Table 4.6: Female PwD Enrolment in Higher Education in Rajasthan (AISHE Report)	
Academic Year	Female PwD Enrolment
2017-18	2,496
2018-19	1,864
2019-20	6,519
2020-21	1,729
2021-22	1,661

Source: Data has been extracted from AISHE website and represented in tabular form

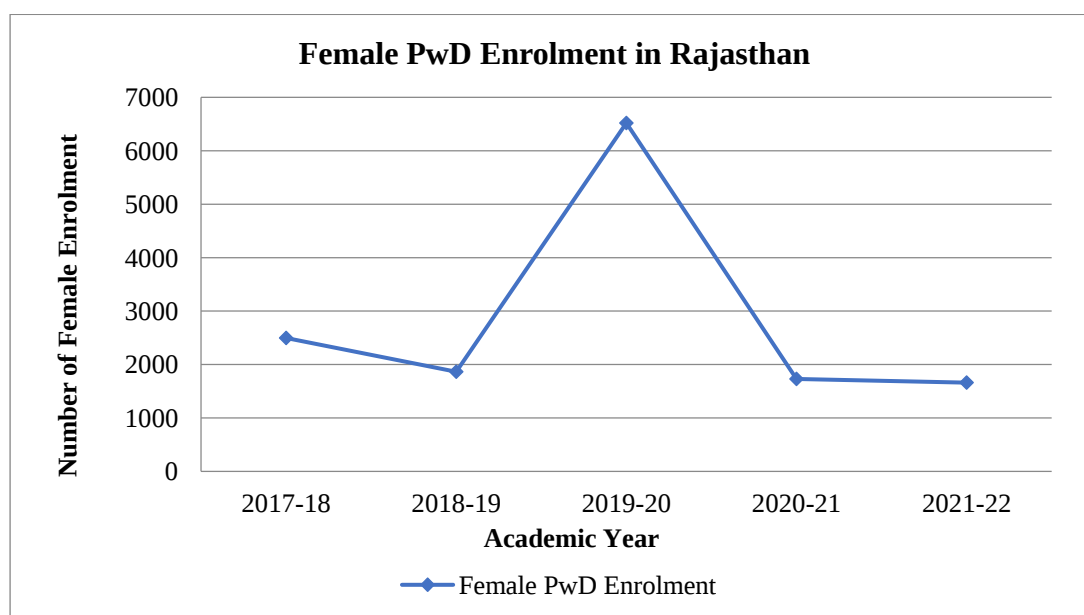


Figure 4.3: Graph representing the declining rate of Enrolment in the Higher Education (AISHE Report)

Source: The graph has been self-made using secondary data from AISHE Reports (2017-2022)

If the anomaly in the year 2019-20 is omitted, the graph is continuously declining.

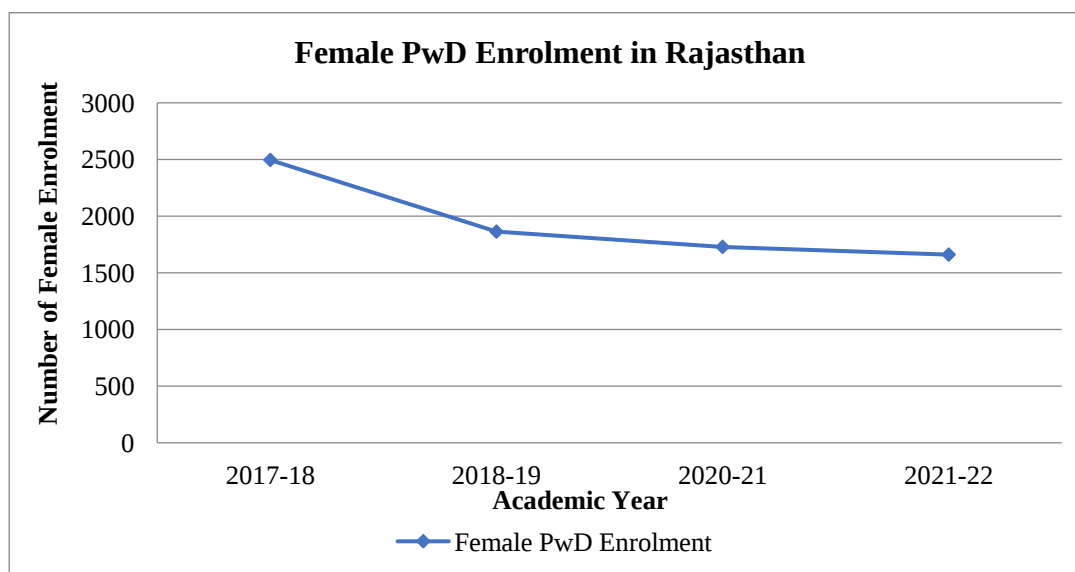


Figure 4.4: Graph representing the continuous decline in the enrolment in Higher Education (omitting the anomaly).

Source: The graph has been self-made using secondary data from AISHE Reports (2017-2022)

Probable reasons for this continuous decline were enquired from the educators and following are the reasons, as per their experience.

Table 4.7. Probable reasons for the decline of admission in the Higher Education <i>(Respondents can choose more than one option)</i>		
Reasons	N=40	Percentage
Lack of accessibility in higher education institutions	20	50%
Financial constraints and limited scholarships for female PwD students	14	35%
Societal norms discouraging higher education for disabled women	24	60%
Fear of safety and lack of secure accommodations for differently-abled women	30	75%
Limited awareness and guidance regarding opportunities for PwD in higher education	30	75%

According to **Table 4.7.**,

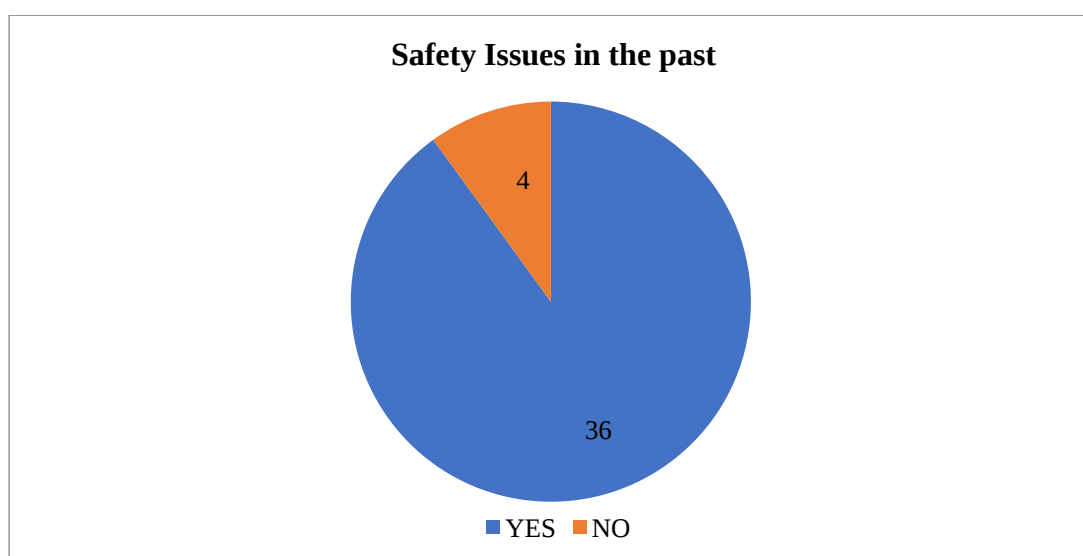
- 75% of instructors believe that **fear of safety and a lack of secure hostel facilities**, as well as **limited understanding and assistance** regarding higher

education choices for PwD students, are the most significant causes for decreased enrolment.

- **60%** of respondents indicated that **societal norms discourage disabled women** from pursuing higher education.
- Half of the participants (**50%**) identify a **lack of accessibility in higher education institutions**.
- **35%** acknowledge **financial constraints and limited scholarships**, indicating that while economic factors are important, socio-cultural and safety-related barriers are viewed as more critical.

4.7.5. Safety Concerns for Differently-Abled Female Students

When enquired whether educators' themselves have faced any safety concerns for their students (especially female) or whether they knew someone who ever faced safety concerns while accessing education as a female differently-abled student, the response is alarming (N=40).



Source: Primary Data

Figure 4.5: Pie-chart Representation of respondents who have faced security issues in relation to female Divyang students.

- **Among the 40 respondents, the vast majority (90%, n=36)** claimed that they or someone they know had experienced safety issues while attending school as a female differently-abled student, illustrating the near-ubiquity of this problem.

- When asked about the most important safety concerns, the most common responses were **inadequate transport facilities and greater vulnerability to harassment or discrimination (30 each)**.
- **26** respondents highlighted a **shortage of secure hostels**, while **16** reported a **lack of female support staff at educational institutions**.

These findings highlight that for differently-abled female students in Rajasthan, the educational environment is shaped by persistent and multi-layered safety concerns, with transportation, personal security, and institutional support remaining pressing gaps, according to educators' collective experience.

4.7.6. Summary of Key Findings

- Economic barriers are almost universal, with inadequate transit (80-89% across districts) and a scarcity of safe hostels (73-100%) posing significant challenges, notably in Kota.
- Attitudinal Barriers indicate strong regional differences, with Jaipur showing more excessive sympathy (73% vs. 11% in Kota), yet both districts had universal family safety worries (78-82%).
- Societal barriers persist in both districts, with orthodox opinions concerning educating disadvantaged females nearly universal (82-89%), indicating widespread cultural reluctance.
- Physical barriers, particularly the lack of schools in rural areas of Rajasthan (78-91%), result in significant geographic exclusion for the great majority of differently abled students especially female.
- The policy-implementation gap is crucial, with 70% of educators reporting inefficient scheme implementation despite full legislative frameworks (RPWD Act 2016, NEP 2020, Sugamya Bharat Abhiyaan).
- NEP 2020 implementation is still being debated among educators, with considerable worries (40-75%) about inclusion and practical difficulties despite ideological commitment to inclusion (55%).
- Higher Education Enrolment Decline is a 33% decrease from 2017-18 to 2021-22, caused equally by safety concerns (75%), knowledge gaps (75%), and societal discouragement (60%).

- Concerns about safety are nearly universal (90%), with transport inadequacy and harassment vulnerability being equally essential (75% each), resulting in an intersectionality of gendered disability vulnerability that institutional mechanisms do not address.

III

4.8. Discussion

The research was motivated due to the declining rate of admission of differently abled girls in Higher education in Rajasthan (Ministry of Education, 2019, 2020, 2021; Ministry of Human Resource Development, 2017, 2017). This study's results show that there are many barriers to education for differently-abled female students in Rajasthan. Educators who spend most time with such students were interrogated via online and offline mode. They made suggestions for how to improve the situation. The educators' proposals provide essential insights into the implementation of policy frameworks - such as the Right of Persons with Disabilities (RPwD) Act 2016, the National Education Policy (NEP) 2020, and the Sugamya Bharat Abhiyaan - at the grassroots level to foster significant educational inclusion. This research brings together these suggestions in five important areas: making systems more accessible and inclusive, combining resources and infrastructure, developing educators' skills, raising awareness and getting people involved, and providing security.

A primary recommendation from educators is the implementation of the Least Restrictive Environment (LRE) principle - a fundamental concept in inclusive education that requires the integration of students with disabilities alongside their non-disabled peers to the greatest extent feasible. The RPwD Act 2016 and NEP 2020 both stress that neighborhood schools should be open to everyone. Studies have previously shown concern over inclusive education. One such study mentioned that

***‘Many teachers are, however, unwilling
to include special needs students
in their classrooms’***

(Bhatnagar & Das, 2014). Even the current research shows that 40% of teachers in this study are worried that inclusive classrooms might make differently-abled students under-confident, and 35% prefer separate special settings even when they are taught together.

Educators' recommendations indicate a significant implementation deficiency: whereas the legal framework necessitates inclusion, the actual means to facilitate effective inclusive practice are lacking (Singal, 2019).

One teacher said that

‘families live in denial for a long time and keep sending their kids with special needs to inclusive settings where they feel inferior and don't learn anything.’

This finding highlights a basic issue: inclusion devoid of adequate support, trained educators, and tailored curricula becomes superficial rather than transformative.

The educators say that LRE should be put into place slowly and based on facts, not as a one-size-fits-all rule. This necessitates:

- (1) initial evaluations of each student's educational requirements,
- (2) structured professional development for educators in differentiated instruction,
- (3) resource assistance within general education settings, and
- (4) continuous oversight to confirm that students with disabilities are not only present but actively engaged in classroom activities (Onyishi & Sefotho, 2020).

The proposals stress that ‘free and appropriate education’ (FAPE) - a key part of the RPwD Act 2016 - must involve not just getting rid of school fees but also changing the curriculum so that it matches the real learning needs of children with disabilities. The study indicated that 82% of teachers in Jaipur say that high school fees for special schools are a problem, and 73% say that the high cost of disability-related equipment is a problem.

One important piece of advice from teachers is to

***‘make the syllabus useful for everyone, like teaching
them life skills instead of $(a+b)^2$ ’.***

This shows a big change in the way we think about education. Instead of making children with intellectual disabilities follow the same academic path as their non-disabled counterparts, special educators suggest a curriculum that focusses on practical life skills, financial literacy, job preparation, and social-emotional learning (Bouck, 2010).

The NEP 2020 says that "teaching-learning e-content created in regional languages" is important, however teachers say that not many people at school know about these kinds of resources (Ministry of Human Resource Development, 2020). Putting the plan into action entails not just making policies, but also giving out resources, training teachers, and setting up systems to make sure that materials get to the right people. Although there are abundant schemes and policies there isn't proper advertisement for the same. TV advertisements, Newspaper articles, Advertisements through street-acts (*nukkad natak*) can be utilized for proper public outreach.

Teachers stress that services that are not connected make things more difficult. A crucial suggestion is:

***"The government should give money to make sure
that all services are in one place."***

Right now, children with disabilities get help through a lot of different, unrelated channels. For example, special educators are in one place, assistive technology resources are in another, vocational training is in another, and health services are in hospitals. This dispersion makes things even harder for families and students. Educators suggest that schools have or be near integrated disability support centres that offer special education, help with and maintenance of assistive technology, health and rehabilitation services, vocational training, transportation coordination, and hostel facilities for people who need a place to live.

The Sugamya Bharat Abhiyaan (Accessible India Campaign) focusses on three areas: the built environment, transportation, and information and communication (Ministry of Social Justice and Empowerment, 2015). However, there is still not enough information about how well it is working. The study indicated that 67% of teachers in Kota and 55% of teachers in Jaipur say that the school infrastructure is not accessible. This means that even though the campaign's goal was to improve physical accessibility at schools, it is still not being done well.

Teachers have made suggestions for infrastructure, such as: Sugamya Bharat Abhiyaan requires ramps, accessible bathrooms, lifts, and tactile walkways, and they must be kept up on a regular basis. Classrooms and play areas that can be used by people with a wide range of disabilities. Schools should supply reliable transport instead of putting the burden on families.

The most common advice from educators fills a big gap:

"Government schools must have Special Educators mandatorily, and students should be encouraged to go into sports and other activities."

The study indicated that 45% of teachers in both districts say that not having enough educated teachers is a problem. Only 2 of the 40 people who answered the survey work in government-inclusive schools; the rest (55%) work in private or NGO special education centres. In Jaipur, as informed by the Special Educators working in Central Schools are only on a temporary basis. It is conditional; based on the admission of any differently abled student in a year. Most regular mode schools don't get any admissions in the whole year. So, the situation is not only critical for the students but also for the faculty who are seeking jobs in the Government schools. The NEP 2020 clearly says that

"there is a need for more special educators who are knowledgeable in both subjects and understand the needs of children with disabilities."

But to do this, the system needs to alter. It is important to prepare, recruit and retain the special educators in Government schools (M. Cooper & Alvarado, 2005).

Educators suggest that every government school with twenty or more differently abled students should have at least one Special B.Ed. qualified teacher on staff. The National Council for Teacher Education (NCTE) and the Rehabilitation Council of India (RCI) are working together to standardize the training and qualifications of special educators. Special Educators stress that children should be ***‘encouraged to go into sports and other activities’*** in addition to their schoolwork. Skill development should be mandatory especially for differently abled students, specifically female who are at an intersection of gender, disability and other marginalized group.

Sports and extracurricular activities develop confidence, social skills, and peer relationships (Palmer et al., 2017). However, 90% of instructors cite safety concerns for female divyang students, which often limit their engagement in school activities.

Creating psychologically safe and physically secure educational environment is a crucial component. One Special Educator during research suggested, ‘Give them a safe, secure, and friendly environment’ and specifically for hostels, ‘a very strong security system with female employees is required.’ According to the report, 75% of educators believe that fear of safety and a lack of secure accommodations are the leading causes of falling higher education enrolment among female students with disabilities. 90% of respondents had personal experience with safety issues involving female differently-abled students.

Safety considerations may include (according to the respondents of this research)

- Transportation vulnerability (mentioned by 30 educators out of 40): Inadequate school transport exposes female students to harassment and accidents.
- Harassment and prejudice (as reported by 30 instructors out of 40) Female students with impairments are more vulnerable to sexual harassment and exploitation.
- Hostel insecurity (mentioned by 26 educators out of 40): Current hostel facilities frequently lack security measures and female staff.

The educational exclusion of females with disabilities cannot be understood solely via a disability or gender lens. Girls with disabilities confront compounded forms of discrimination as a result of the confluence of various identification markers - disability, gender, socioeconomic class, and location - creating unique experiences that are qualitatively distinct from the sum of their individual parts. An intersectional approach demonstrates how gendered dimensions of vulnerability, safety, and access interact with disability-related barriers, necessitating comprehensive policy solutions (Liasidou, 2013).

The educator's suggestions highlight:

‘Spread awareness among parents and society run programmes for parents of special children teach them how to handle special children more effectively.’

The study found significant attitudinal and cultural impediments, with 82-89% of educators reporting traditional ideas about teaching impaired girls and 100% of Kota respondents indicating a lack of societal support for disabled girls' education. Currently, 70% of educators claim that government plans are not being adequately implemented at the grassroots level, indicating a lack of awareness among both implementers and the general population. Educators recommend comprehensive awareness efforts that address: Foundational understanding that education is not optional for differently-abled youngsters and that they can compete on par with their non-disabled counterparts Parent and community involvement through a specialised parent training program. Teaching effective techniques to support learning at home. School-based awareness by including disability education into regular curricula to foster peer acceptance and understanding should be included in the curriculum. According to one educator,

‘People in our society believe there is no benefit to teaching these kids; they treat them as a burden.’

Furthermore, they are concerned that despite their schooling, they would be unable to compete, which underscores the fundamental misunderstanding that must be

addressed. Evidence-based awareness campaigns should include instances of differently abled people achieving in education and employment (Naraharisetti & Castro, 2016).

Although more than 50% of the special educators are in favour of inclusive education yet rest of them have mixed thoughts regarding the same. Still 40 % of the respondents believe that inclusive education will undermine the confidence of the special children. and 35% (n=14) preferred a separate special setting even if taught together which is contradictory to the previous suggestions by NCERT which advocates for strategies that integrate all students within the regular classroom rather than removing some for learning in segregated settings (Julka, 2015).

4.9. Policy Recommendations

1. Provide Economic Assistance at every step

Economic constraints remain one of the most major impediments to education for differently abled female students. Educators frequently report transit issues, lack of safe hostel facilities for girls, high equipment prices, and high school fees for private tuitions. While laws such as the RPwD Act of 2016, Samajik Suraksha Pension, and disability-focused scholarship schemes exist, these benefits are not widely known or accessible (even by the special educators). Financial assistance must be tailored to genuine disability-related expenses, and transportation subsidies or school-arranged transportation should be offered.

2. Improve Inclusivity

To improve inclusion, plans must be communicated through many channels in local languages, a streamlined single-window application and payout through schools, and eligible kids must be identified in advance. External audits, female wardens trained in child protection, confidential grievance processes, medical and mental health care, and community oversight committees are all required for hostels.

3. Security for female students

A secure hostel infrastructure with regular surveillance, female staff, and gender-sensitive services is required. Although policy frameworks are broad, ground-level

execution is inadequate. Institutions report inadequate resources, irregular monitoring, and a lack of trained people.

4. Infrastructure in rural areas

Many special educators mentioned that the female divyang students who are in rural areas go to regular schools in the initial years, later they drop out due to lack of special facilities in the rural areas. To improve service delivery, NGOs and special education centres require targeted funding, technical support for evidence-based approaches, and the regularisation of special educators and support workers.

5. Continuous monitoring of Quality Education

Quality assurance should be reinforced with regular inspections, audits, and accreditation. Tracking student outcomes from school to job will assist in determining the effectiveness of inclusive education initiatives. Students should learn at least one skill that can give them employment while they are in school itself.

6. Bridge the gap between Policy and Implementation

The gap between policy aims and implementation remains large. Translating national frameworks like the RPwD Act, NEP 2020, and Sugamya Bharat Abhiyaan into school-level action plans necessitates clear standards, committed oversight at the block and district levels, and ongoing capacity building for administrators. Monitoring systems must keep track of critical metrics such as the identification of children with disabilities, the recruitment of special educators, accessibility improvements, and scholarship awarding. Frontline educators' feedback should inspire policy refinement, and resource allocation must be commensurate to need, especially in places with a large number of differently abled learners.

7. Ambitious Awareness Schemes

Outreach programs and awareness schemes should be ambitiously done via media, posters, *nukkad nataks* for general public to generate awareness regarding differently abled citizens of India. Everyone should be aware of their rights, not only the differently abled students. Although schemes exist on paper, lack of awareness

even among the special educators doesn't reflect their negligence but lack from the Government which cannot spread awareness as much as it should have been.

Disability, gender, economic constraints, geographic isolation, and institutional limitations all play a role in educational exclusion for differently abled females. Improving inclusiveness requires a comprehensive and coordinated effort. An effective system must be founded on rights-based law, supported by skilled staff and accessible infrastructure, financially sustainable through coordinated schemes, socially transformative through stigma reduction activities, and institutionally safe, with special safeguards for girls. Focusing on outcomes - educational attainment, social integration, and transition to employment - will ensure that inclusive education leads to meaningful empowerment. The present legal and policy framework is good; what is required now is committed, well-coordinated implementation supported by enough resources, institutional capability, and strong accountability mechanisms.

4.10. Conclusion

The decline in admission of female students (divyangjan) in Rajasthan is not due to absence of policy, but due to the fundamental gap between comprehensive legal frameworks and their ground-level implementation. While the RPwD Act 2016, NEP 2020, and Sugamya Bharat Abhiyaan provide robust policy architecture, special educators' voices, who spend most of their time with such students reveal that these policies remain disconnected from the lived realities of differently-abled female students. They continue to face compounded barriers rooted in economic deprivation, social stigma, geographic isolation, and institutional inadequacy. The educators' recommendations point toward a coherent vision: inclusive education for girls with disabilities requires not merely policy initiation but committed implementation through trained personnel, integrated services, accessible infrastructure such as safe and secure hostel facilities for female, special toilets, financial support mechanisms, and unwavering institutional safeguards. It should be a fundamental understanding that education is not a privilege but a right, and that differently-abled girls possess both the capacity and entitlement to educational achievement and participation at par with their non-disabled peers. Without such coordinated, multi-level action, the gap between policy initiation and educational outcomes will persist, creating the exclusion that current data tragically demonstrates.

Chapter 5

Conclusion

CHAPTER 5

CONCLUSION

The objective of this chapter is to summarize the major findings of the study and to suggest policy interventions emerging from the analysis of the data. This chapter has been organized into four sections.

The **first section** discusses the following:

- **Rationale and Contemporary Relevance of the study**
- **Summary of Review of Literature**
- **Summary of Research Gap and Inferences drawn**
- **Locale of the study**
- **Scope of the study**

The **second section** discusses the following:

- **Objectives**
- **Hypotheses**

The **third section** discusses the Major Findings from each chapter:

- **Adolescent Mental Health**
- **Postpartum Mental Health**
- **Education for Divyang Women**

The **fourth section** discusses the following:

- **Policy Recommendations**
- **Contribution to Knowledge**
- **Limitations of the study**
- **Future Research Directions**

I

5.1. Rationale and Contemporary Relevance of the study

Women's Empowerment cannot be considered as a static goal; instead, it is a continuously evolving process shaped by social, economic, political, and institutional contexts. The access to mental health services to women at every age and need is not only a matter of equity and social justice but also holds significant implications for the socio-economic development of a country. The same is true for the education of differently abled women and monitoring their enrolment and drop-out rate in educational institutions. Ensuring health of female in totality- mental and physical and Education for all- regular and special will bring a holistic change and make the nation Developed in true sense.

Mental health issues, as mentioned before, especially Depression affects more female than men. In their adolescence age it affects their interests in study and thus negatively affecting the future. And in the reproductive age, it can severely affect not only the mother's health in the future but also raise emotionally unstable kids due to weak mother-child bond.

As inclusive members of the nation, Divyangjan contribute significantly to the human resource pool, and their inclusion in higher education is significant for harnessing their potential. It becomes imperative when the gender is female due to her intersectionality of gender and disability sometimes topped with caste, class, region and poverty.

Thus, present study becomes highly relevant. This study aims to determine and assess the mental health of women in to crucial stages of their life and the access and hindrance to higher education for differently-abled female in the state of Rajasthan. The aim is to identify various factors that contribute to postpartum mental health crisis in women, how and how much does stress and other mental health indicators affect adolescent female and what are the various reasons for the drop in enrolment of differently-abled female of Rajasthan in the higher education.

5.2. Summary of Review of Literature

The reviewed literature in Chapter 1 (Introduction) for all the three chapters collectively establishes mental health and education as central pillars of women's empowerment, examined across the life course - from adolescence to motherhood and disability. In the context of **Adolescent and Postpartum mental health**, government policies and international frameworks (WHO, UNICEF, National Mental Health Policy, Mental Healthcare Act, National Mental Health Programme, and other maternal health schemes) recognise mental health as a rights-based and public health priority. Despite that, across both life stages i.e., adolescents and reproductive age, a persistent 'treatment gap' emerges. Various reasons are attributed for the same which includes but are not limited to stigma and shame, inadequate screening, limited specialised services, and weak integration of mental health into primary and maternal healthcare. Research evidence and Government data (International and National) consistently highlights high prevalence rates of depression, anxiety, stress, and suicide risk among adolescents and mothers stemming from academic pressure, unrealistic familial expectations, dual burden, socio-economic vulnerability, and lack of general awareness acting as key determinants. Studies further demonstrate that while policy intent exists, implementation remains fragmented - particularly for postpartum mental health, which continues to lack explicit, structured interventions despite its proven impact on maternal and child well-being; becoming a strong example of gender discrimination. Policies exist to address other mental health crisis. But no special attention has been given thus far because it affects just one gender i.e., female. Books and expert works reinforce the need for early identification, non-judgmental support systems, awareness schemes, community sensitization, and continuity of care across adolescence and motherhood.

The other section of the study i.e., 'education for differently-abled women', policies such as the National Education Policy 2020, Rights of Persons with Disabilities Act 2016, Sugamya Bharat Abhiyaan etc. emphasize inclusive, accessible, and rights-based education. Yet empirical studies reveal substantial gaps between policy and practice. Previous research consistently highlights intersecting barriers of gender,

disability, class, caste, and geography that limit enrolment, retention, safety, and post-school opportunities for disabled female. Constraints such as inadequate infrastructure, shortage of trained teachers, societal stigma, safety concerns, and weak transition pathways beyond elementary education continue to be an excuse to avoid inclusion. International and Indian scholarship stresses that inclusion must move beyond physical access to address deeper institutional, cultural, and attitudinal barriers through joined efforts of individual and institution. Books further contextualize these challenges historically and pedagogically, highlighting education as a transformative tool for women's empowerment while underscoring the need for sustained teacher training, parental engagement, data transparency (notably the absence of recent AISHE reports), and systemic reforms for the disabled female. Overall, the literature meets on the conclusion that holistic empowerment requires integrated, continuous, apropos and intersectional policy approaches that simultaneously address mental health, education, and intersectionality of both.

5.3. Summary of Research Gap and Inferences drawn

The review of literature across the three dimensions (which is discussed in detail in Chapter 1- Introduction) which includes **adolescent mental health of female, postpartum mental health, and education of Divyang women**. It reveals substantial researches, policy attention, and empirical evidence at national and international levels. Despite this breadth of work, the literature also exposes **specific policy interventions, geographic disparities, gender-specific, and administrative gaps** that justify the present study.

First, in the area of **adolescent mental health**, existing research establishes a high prevalence of mental health disorders and a major lack of identification of the same for a very long time, particularly in urban and competitive academic environments. Yet, most Indian studies disproportionately focus on high-profile locations such as Kota which is always in media-attention, often neglecting Jaipur, the state capital, which has distinct urban, socio-cultural, and educational dynamics. Moreover, despite global evidence that adolescent girls are more vulnerable to depression and anxiety, **gender-specific studies focusing exclusively on female adolescents are notably scarce**. The literature further lacks **comparative, age-disaggregated**

analysis (15–17 vs. 17–19 years) and systematic examination of **living arrangements (home-based vs. independent living)** which automatically believes that students are suffering because they are away from home. Additionally, while prevalence is well-documented, **help-seeking behaviour remains underexplored**, particularly in the context of stigma, accessibility, and social and cultural norms in Rajasthan.

Second, in the domain of **postpartum mental health**, research highlights alarmingly high prevalence rates of postpartum depression in India and persistent issues of low awareness, under-diagnosis, and under-treatment. However, a significant gap exists at the **policy-administration convergence**. Major maternal and mental health policies and programs such as the National Health Mission, Pradhan Mantri Surakshit Matritva Abhiyan, National Mental Health Programme, and National Mental Health Policy majorly focus on physical health and provide no specific, operational framework for postpartum mental health care. Moreover, frontline health workers such as ASHAs are not institutionally trained or guided to identify or manage maternal mental health concerns. From a research perspective, most studies are clinical or psychological in nature, with **limited administrative, policy-oriented, or system-level analysis**, and very few incorporate the perspectives of **healthcare providers such as gynecologists and psychiatrists**. Region-specific evidence from the state of Rajasthan particularly Jaipur and Kota is also sparse, despite the state's unique socio-cultural and healthcare barriers.

Third, with regard to the **education of Divyang women**, while inclusive education frameworks such as the Rights of Persons with Disabilities Act, 2016 and National Education Policies, 2020 exist, the literature consistently shows a gap between policy intent and ground-level implementation. Research confirms that **intersectionality of gender and disability** are a troubling issue, yet **district-level, gender-specific analyses** remain limited. In Rajasthan, the documented decline in female Divyang enrolment in higher education since 2017 (as per AISHE reports) has not been adequately investigated. Additionally, the perspectives of **special educators on inclusive education**, its feasibility, and its effectiveness under NEP 2020 are insufficiently studied, despite their central role in implementation.

In light of these gaps, the present study is based on a **comparative, gender-sensitive, and public administration-oriented framework**. It aims to address neglected intersections of **gender, age, location, living conditions, disability, help seeking behavior and governance** within the state of Rajasthan. **Jaipur and Kota districts** act as microcosm of Rajasthan. By centring **female adolescents, postpartum mothers, and Divyang women**, it foregrounds populations that experience intersectional vulnerabilities yet remain underrepresented in policy-responsive research. Finally, by incorporating the perspectives of **healthcare professionals and special educators**, the study aims to bridge the persistent divide between lived experiences, service delivery, and policy design hence contributing empirically and analytically to public administration, gender studies, and psychological necessities of the time.

5.4. Locale of the study

The state of Rajasthan, particularly Jaipur and Kota districts were chosen for the study for the following reasons.

- Rajasthan is the largest state of India with an area of 342,239 km² and it is not feasible to cover the entire state. Hence two districts were chosen for the study since these two districts together capture the diversity and intensity of Rajasthan's healthcare landscape.
- Rajasthan in particular was selected because as evident in the National Mental Health Survey (2015–16), Rajasthan reports alarmingly higher prevalence of neurotic and stress-related disorders in the state, pointing toward the need for district-level inquiry.
- Jaipur, as the state capital and largest urban center of the state functions as the primary referral hub for Rajasthan, with a dense concentration of tertiary and secondary healthcare institutions serving urban, semi-urban, and rural populations from the entire state. Moreover, Jaipur is becoming a hub for educational centres.
- Kota, while smaller in administrative stature, represents a distinct urban health context as a medical education center with multiple teaching hospitals and a sizeable government and private healthcare facilities. Kota also is a

traditional hub for coaching centres and still attracts lakhs of student every year.

- Examining of these two districts helps in comparative understanding of mental health service availability, access, and utilization across differing urban health systems, while capturing the experiences of adolescent populations drawn from varied socio-geographic backgrounds.
- For the education component, Jaipur and Kota were purposively selected due to their central role in Rajasthan's educational ecosystem and their high concentration of divyang women from all over Rajasthan.

5.5. Scope of the study

The current research examined women empowerment in Rajasthan with a special focus on health and education of women in the districts of Jaipur and Kota. Empowerment can be achieved through good health and educating women. Health was divided into two parts i.e., Mental Health and Physical Health. This research studied the mental health of women specifically adolescent mental health (aged between 15 to 19) and postpartum mental health. Whereas in Education for Women, the research dove into education for differently-abled women in Rajasthan; focusing on the declining rate of admission of female differently abled students in the higher education.

This holistic study of two age variation i.e., Adolescence and Postpartum (reproductive age) will help the policy makers to make policies that are carved for specific need of the two age groups. Since, the needs and priorities of both age groups is extremely unique, it demands specific policies for each.

Similarly, the research will also help policy makers to make better policies to limit the drop-out rates of Divyang female and motivate more admissions in the higher education in Rajasthan. It will also aid in the better understanding about the complexities of inclusive education, which will help future policy makers to keep the views of both parents and special educators while making decisions for differently abled students. It is extremely important to keep security in center for female students, especially when they are at an intersection of gender and disability; sometimes even caste, class and region.

II

5.6. Objectives of the study

- To find out Frequency of overwhelm in Jaipur and Kota districts of Rajasthan amongst female students aged between 15-17 and 17-19 years of age and analyze the same.
- To analyze the prevalence of Mental health symptoms such as Anxiety, Loneliness, Panic Attacks, persistent sadness and suicidal thoughts in female students aged between 15-17 and 17-19.
- To analyze the prevalence of various mental health indicators in female adolescent students in Jaipur and Kota districts.
- To study the residence based (at home versus away from home) mental health issues in female adolescents in Jaipur and Kota districts.
- To compare the mental health issues prevalence and help-seeking behavior for the same in female adolescent students in Jaipur and Kota districts.
- To understand how satisfied female adolescent girls are with the administrative support provided by the local, state and National Government for the mental health issues and academic stress.
- To understand Family related factors that cause post-partum mental issues in the mothers of Rajasthan.
- To analyze the Delivery related issues that creates in post-partum mental health issues in the mothers of Rajasthan.
- To analyze the societal and the cultural expectations on Maternal Mental health.
- To find out how many healthcare providers belief that cultural issues impact Postpartum mental health recognition and treatment.
- To investigate an estimate of clinical diagnosis rate of postpartum depression and barriers to effective Postpartum Depression Management.
- To interrogate from the healthcare professionals on how aware a Rajasthani mother is regarding mental health services and what is the Help-seeking rate.
- To inquire from the healthcare professionals about general Public Awareness and Support System provided to the mother.

- To understand how literacy rate is associated with the awareness of postpartum mental health.
- To understand the role of healthcare providers, Government (local, state and central) in managing postpartum mental health issues.
- To investigate the long-term effect of Post partum mental health issues as perceived by the healthcare providers on the women's future.
- To analyze the declining enrollment of Divyang female students in higher education institutions in Rajasthan (AISHE Report 2017-2022) and identify the underlying causes from educators' perspectives.
- To evaluate the awareness, effectiveness, and grassroots-level implementation of government policies and schemes among educators (including Sugamya Bharat Abhiyaan, RPwD Act 2016, and NEP 2020) for the education of differently-abled female students.
- To identify and analyze the **attitudinal barriers** preventing differently-abled female students from accessing quality education in Jaipur and Kota districts of Rajasthan.
- To identify and analyze the **societal barriers** preventing differently-abled female students from accessing quality education in Jaipur and Kota districts of Rajasthan.
- To identify and analyze the **economic barriers** preventing differently-abled female students from accessing quality education in Jaipur and Kota districts of Rajasthan.
- To identify and analyze the **physical barriers** preventing differently-abled female students from accessing quality education in Jaipur and Kota districts of Rajasthan.
- To investigate the severity of safety concerns faced by differently-abled female students that is being a hindrance in seeking education.

5.7. Hypotheses

1. Hypothesis Related to District wise Differences (Jaipur and Kota)

- **Frequency of overwhelm**
- **Academic Stress levels**
- **Mental Health Indicators**

- **Help-Seeking Behavior**
 - **Awareness of Mental Health Support Systems**
 - **Perceived Satisfaction with Security Measures**
2. **Hypotheses Related to Age Differences**
 3. **Hypotheses Related to Place of Stay**

Note: Formal hypotheses were not formulated for the 3rd and 4th chapters on Postpartum mental health and Education of differently abled women respectively because the nature of the inquiry was descriptive and analytical rather than inferential. These chapters were designed to systematically collect data from the stakeholders (their experience and perspectives), document of existing conditions, institutional practices, and policy implementation gaps using descriptive data. Since the variables examined such as availability of services, institutional preparedness, awareness levels, perceived barriers etc. did not require statistical testing or measurement of causal relationships, the application of inferential statistical tests was not methodologically apt.

III

5.8. Summary of the Results

5.8.1. Major Findings from Chapter 2 (Adolescent Mental Health)

Data was collected from **560 female adolescents** from **Jaipur (N=290)** and **Kota (N=270)** aged between 15-19. From **Jaipur, 80 female adolescents were between 15-17 age group** whereas **210 were from 17-19 age group**. From **Kota, 75 students were from 15-17 age group** whereas **195 were in the age group of 17-19**.

The data was collected using **purposive, convenient and snowball sampling** through Questionnaire distributed personally and through Google Forms.

The data was further calculated and analyzed using Microsoft Excel. Tests were applied using Microsoft Excel.

The following table enlists all the statistically significant results obtained from the collected data and its interpretation.

Table 5.1: Summary of Statistically Significant Hypothesis Testing Results and its Interpretation from Chapter 2: Adolescent Mental Health

S. No.	Null Hypothesis	Test used	p-value	Decision	Meaning of the Result
1.	There is no significant difference in the frequency of overwhelm among female adolescent students between Jaipur and Kota districts.	Chi-Square Test	0.0045	Null Hypothesis Rejected Statistically significant	A significant association between district and frequency of overwhelm was found, female adolescents from Jaipur reported higher frequency of overwhelm compared to those from Kota
2.	There is no significant difference in the academic stress levels among female adolescent students between Jaipur and Kota districts.	Independent sample t-test	<0.001	Null Hypothesis Rejected Statistically significant	The rejection of the null hypothesis indicates a significant difference in academic stress levels among female adolescent students between Jaipur and Kota districts. With Jaipur district reporting significantly higher academic stress compared to their counterparts in Kota
3.	There is no significant difference in anxiety or stress among female adolescent student between Jaipur and Kota districts.	Chi-Square Test	0.020	Null Hypothesis Rejected Statistically significant	The results revealed a significant difference in anxiety or stress among female adolescent students between Jaipur and Kota districts. Female adolescents from Jaipur reported significantly higher anxiety or stress than those from Kota
4.	There is no significant difference in Loneliness among female adolescent student between Jaipur and Kota districts.	Chi-Square Test	0.0006	Null Hypothesis Rejected Highly significant	The rejection of the null hypothesis indicates a significant difference in loneliness among female adolescent students between Jaipur and Kota districts, with students from Jaipur reporting significantly higher loneliness compared to their counterparts in Kota

5.	There is no significant difference in Persistent sadness/hopelessness among female adolescent student between Jaipur and Kota districts.	Chi-Square Test	< 0.001	Null Hypothesis Rejected Highly significant	Rejection of the null hypothesis revealed significantly higher Persistent sadness/hopelessness. among female adolescents in Jaipur compared to Kota
6.	There is no significant difference in suicidal thoughts among female adolescent student between Jaipur and Kota districts.	Chi-Square Test	0.0007	Null Hypothesis Rejected Highly significant	The results revealed a significant difference in suicidal thoughts among female adolescent students between Jaipur and Kota districts. Female adolescents from Jaipur reported significantly higher suicidal thoughts than those from Kota
7.	There is no significant difference in help seeking with Therapy or Counselling among female adolescent student between Jaipur and Kota districts.	Chi-Square Test	0.0001	Null Hypothesis Rejected Highly significant	The rejection of the null hypothesis indicates difference in the two cities when it comes to help seeking with Therapy or Counselling, with female students in Kota reporting significantly higher levels of help-seeking through therapy or counselling
8.	There is no significant difference in help seeking with Therapy or Counselling among female adolescent student between Jaipur and Kota districts.	Chi-Square Test	0.0205	Null Hypothesis Rejected Moderately significant	The rejection of the null hypothesis indicates a significant association between the districts of Kota and Jaipur, and avoidance of help-seeking due to the belief that issues will resolve on their own. With female adolescent students from Kota reporting significantly higher avoidance.
9.	There is no significant difference in not seeking help due to the lack of access to resources among female adolescent student between Jaipur and Kota districts.	Chi-Square Test	0.0002	Null Hypothesis Rejected Highly significant	A significant association between district and avoidance of help-seeking due to lack of access to resources was found, female adolescents from Jaipur reported higher avoidance due to lack of access to resources

					compared to those from Kota
10.	There is no significant difference in awareness of mental health support systems among female adolescent student between Jaipur and Kota districts.	Chi-Square Test	<0.001	Null Hypothesis Rejected Highly significant	Rejection of the null hypothesis revealed significantly higher awareness of mental health support systems. among female adolescents in Jaipur compared to Kota
11.	There is no significant difference in Loneliness between younger (15-17 years old) and older (17-19 years old) female adolescents.	Chi-Square Test	<0.001	Null Hypothesis Rejected Highly significant	The results revealed a significant difference in loneliness among female adolescent students between the two age groups. Female adolescents from 17-19 age group reported significantly higher loneliness than those from 15-17 age group.
12.	There is no significant difference in Persistent Sadness or Hopelessness between younger (15-17 years old) and older (17-19 years old) female adolescents.	Chi-Square Test	<0.001	Null Hypothesis Rejected Highly significant	The rejection of the null hypothesis indicates a significant difference in Persistent Sadness or Hopelessness between younger (15-17 years old) and older (17-19 years old) female adolescents, with age group 17-19 reporting significantly higher Persistent Sadness or Hopelessness than those from 15-17 age group.
13.	There is no significant difference in Persistent sadness or hopelessness staying at home and those staying away from home.	Chi-Square Test	0.002	Null Hypothesis Rejected Statistically significant	A significant association between place of stay (at home, away from home) and issue of Persistent sadness or hopelessness was found, female adolescents staying at home reported significantly higher persistent sadness or hopelessness compared to those away from home.

14.	There is no significant difference in Anxiety or excessive worry between female adolescent students staying at home and those staying away from home.	Chi-Square Test	0.013	Null Hypothesis Rejected Statistically significant	The rejection of the null hypothesis indicates a significant difference in Anxiety or excessive worry between female adolescent students staying at home and those staying away from home. With those staying at home reporting significantly higher Anxiety or excessive worry.
15.	There is no significant difference in Suicidal thoughts between female adolescent students staying at home and those staying away from home.	Chi-Square Test	0.032	Null Hypothesis Rejected Statistically significant	The rejection of the null hypothesis indicates a significant difference in Suicidal thoughts between female adolescent students staying at home and those staying away from home. With those staying at home reporting significantly higher Suicidal thoughts compared to those staying away from home.

5.8.2. Major Findings from Chapter 3 (Postpartum Mental Health)

Data was collected from 52 healthcare professionals from Jaipur and Kota combined with 34 Gynecologists (65.4%), 7 Psychiatrists (13.5%) as the major population.

Data was collected using Purposive and convenient sampling. The data was collected through personal interviews and Google Forms.

Summary of key findings are tabulated below.

Table 5.2: Summary of the Key Findings from Chapter 3: Postpartum mental health		
S.No.	Thematic Area	Consolidated finding
1.	Biological, Psychological, and Social Risk Factors	Female child born, financial difficulties and past history of psychiatric illness or anxiety were reported as the main causes by more than 69 % of doctors.
2.	Family-Related Factors	Lack of partner support and lack of family support were reported by 77% and 69% doctors respectively. More than 50% report Marital Discord as one of the major risk factors for postpartum depression.
3.	Delivery-related Factors	Unplanned pregnancy was reported by more than 69% of doctors as the delivery-related cause for postpartum depression.
4.	Societal Expectations	Gender preference pressure, Pressure to return to normal roles quickly, Expectation to prioritize child over personal health was reported by more than half of the respondents as contributing factors to postpartum mental health issues.
5.	Impact of Cultural Beliefs on Postpartum Mental Health	Maximum respondents that are 46.2 % report that cultural beliefs significantly hinder recognition and treatment.
6.	Prevalence and Diagnosis	On one hand, 16 out of 52 respondents report that no such data is available which estimates number of cases found per 1000 patients of postpartum depression whereas 24 out of 52 suggest that 0-10% of cases come according to their clinical experience per 1000 patients.

7.	Barriers to Management	Lack of awareness among mothers, non-availability of mental health professionals and Fear of stigma among patient's families are few among many barriers to effective postpartum Depression management. These reasons are frequently marked by the healthcare providers (more than 30%).
8.	Maternal Awareness of Mental Health Services	More than 50% of respondents believe that the mothers are unaware of the mental health services facilities.
9.	General Public Awareness of Postpartum mental health issues	92.4% of respondents are split between the opinion that the general public is either somewhat aware or not very aware (46.2% each) of the postpartum mental health issues.
10.	Help-seeking rate in Mothers	Almost 70% of the healthcare providers have observed that less than 10% of the mothers seek help even when they need it.
11.	Methods used by mothers to get help for mental health issues	84.6% of the healthcare providers believed that support from extended family is most beneficial followed by 77% of them believing in professional help .
12.	Effect of education level of mother on Postpartum mental health	Healthcare professionals are split between no formal education and similar prevalence across all educational levels ; each reported by 30.8% of the respondents.
13.	Healthcare Providers' strategies	More than 75% of the respondents provide emotional support and refer them to mental health services . Whereas more than 45% of them identify depressive thoughts, apply behavioral modification technique or assist with decision making . But, without any standard tools for testing the issue.
14.	State Government Initiatives	As per their clinical experience, more than 50% of the respondents believe that no initiatives are being taken for the prevention and cure of postpartum mental health issues.
15.	Central Government Initiatives	Almost 70% of the respondents report maternity leave policies as beneficial for mothers followed by Pradhan Mantri Surakshit Matritva Abhiyaan (as reported by more than 60% of the respondents).

16.	Perceived Effectiveness of State/Local Government Initiatives	No healthcare professional reported any initiative as ‘ very effective ’. More than 80% reported it as Somewhat effective .
17.	Postpartum issue as an issue of modern civilization.	More than 60% of respondents note postpartum depression as an issue of modern civilization
18.	Long term effect of untreated postpartum mental health issues	More than 75% of healthcare professionals in their clinical experience have seen relationship issue with partners or family members in long term if mental health issues after delivery are ignored and more than 50% report its impact on mother-child bond .

5.7.3. Major Findings from Chapter 4 (Education of Divyang Women)

Data for this chapter was collected from educators from **Jaipur (22) and Kota (18)** combined. 16 of them were from Private (Exclusive) setting, 22 from NGOs and Special Education Centres, and 2 from Government school with inclusive setting. Most of the educators had Special B.Ed. degree. The data was collected using Purposive sampling via Google Forms and personal interviews. Group Discussions were also conducted for Qualitative study.

Table 5.3: Summary of the Key Findings from Chapter 4: Education for Divyang Female		
S. No.	Key Areas	Explanation
1.	Economic Barrier to education	Lack of safe hostels for female differently-abled students is major reason in Kota with 100% of educators reporting it as an issue. In Jaipur , School fees for special schools were reported by 82% of the educators.
2.	Attitudinal Barrier	100% of educators in Kota believe that Society does not provide strong support for the education of disabled girls whereas Family’s over-protection and safety of female disabled child was reported as a major concern by the educators (82%) in Jaipur .
3.	Societal Barriers	Both Jaipur (82%) and Kota (89%) blame orthodox beliefs such as the purpose of educating

		a girl child, especially disabled ones as the leading societal barrier.
4.	Physical Barriers	Both Jaipur (91%) and Kota (78%) believe Absence of schools for differently-abled students in rural areas as the leading physical barrier.
5.	Policy Awareness	70% of educators believe that no schemes or policies are implemented as effectively as they should be for the education of differently abled female students in Rajasthan.
6.	Inclusive Education	55% of respondents agreed that teaching both categories of students will promote a sense of brotherhood. 40% of respondents felt that inclusive classrooms may undermine the confidence of differently-abled students; 35% preferred a separate special setting even if taught together.
7.	Declining rate of admission	75% of respondents believe that Fear of safety and lack of secure accommodations for differently-abled women and Limited awareness and guidance regarding opportunities for PwD in higher education are major reasons for the decline of enrolment of female PwD students in Rajasthan from 2017-2022 (AISHE Report).
8.	Safety concerns for students	90% of educators claimed that they or someone they know had experienced safety issues while attending school as a female differently-abled student. 75% of educators identified inadequate transport facilities and greater vulnerability to harassment or discrimination as the most urgent safety concern.

IV

This section discusses the Policy Recommendations, Contribution to Knowledge, Limitations of the study and the Future Research Directions.

5.9. Policy Recommendations

▪ **Exclusive Government Policy for Adolescent Population**

India has the largest adolescent population in the world, with 253 million, and every fifth person is between 10 and 19 years old (UNICEF, n.d.). But no policy exist which is exclusively for this age group. India needs a policy which is directed towards the mental and physical health of adolescents, thus securing the future of a nation with million youth.

▪ **Mandatory and Regular mental health screening for Adolescents**

Currently, mental health services are available for students on a voluntary and self-reporting basis. But the current research underscores a deeper issue and highlight a critical limitation of this approach. Many students who are suffering from mental health issues are not seeking help even when the facilities are available due to stigma, shame, belief that it will resolve on its own and inability to recognize symptoms of psychological distress.

In this context, regular and mandatory mental health screening (like regular health check-ups for physical health) will help identify students who are facing mental health crisis. Periodic screening within schools, colleges, and coaching institutions would facilitate early identification of anxiety, panic attacks, loneliness, academic stress that leads to depression thereby enabling timely intervention and reducing the risk of severe mental health crises and risky behavior.

▪ **Regular Monitoring of Mental Health in Coaching and Educational Hubs**

Kota has received substantial media and governmental attention due to reported student suicides, making it as a focal point of concern for adolescent mental health. However, the findings of this study present a more nuanced picture Kota continues

to warrant focused intervention, but the mental health issue in Jaipur has spread its root deeper and wider in female adolescents.

This indicates that mental health issues are not confined to a single District in Rajasthan but are widespread across institutional clusters with high student concentration.

Hence, monitoring of mental health of students should be regular and uniform wherever there are student crowd and institutional hub, throughout Rajasthan.

▪ **Attitude shift among Parents and Adolescents**

Contrary to the commonly held belief that students staying away from home feel more loneliness, anxiety and other mental health issues, this research shows that students in Jaipur and Kota districts feel lesser stress away from home.

This requires urgent attention and attitude shift from parents whose unintended pressures exerted by excessive monitoring, academic expectations and control somehow cause stress on the young growing minds.

These findings necessitate urgent attitudinal shift among both parents and adolescents. Awareness schemes and regular counseling should be institutionalized and mandated, similar to parent- teacher meetings in schools. Such initiative will help parents better understand their adolescents and adopt supportive rather than pressure-inducing approaches for their ward's career.

▪ **Exclusive Government Policy on Postpartum mental health**

The findings of the present study indicate the absence of a exclusive and specific policy framework addressing postpartum mental health issues in India. While maternal health policies primarily emphasize physical outcomes such as safe delivery and postnatal recovery, mental health of mothers remain largely neglected. Although District mental health programs exist, the healthcare providers in current study report that there is no screening at all for any signs of postpartum mental health issues; focus remains on physical health only.

The data on current and previous studies show a prevalence of 10-25% of postpartum issue in Indian mothers. A country with billion mothers deserves a policy that should consist of awareness schemes not only among the mothers but also the general public. Integrated approach in the existing health institutions is required to strengthen the mental health crisis in mothers.

▪ **Strengthening Screening and Integration within Existing Health Systems**

The study highlights the need to strengthen and operationalize existing maternal and mental health policies too. Frontline healthcare workers such as Accredited Social Health Activists (ASHA) workers have greater outreach and are trustworthy by the families usually in the rural background. They should be trained to identify and then counsel the new mothers and their families in gentle manner.

In addition, cultural shift should be targeted. Precautionary counseling should be institutionalized in the hospitals itself, irrespective of the presence of visible symptoms. This will help the family with a basic understanding of postpartum mental health enabling them to act accordingly if symptoms emerge.

▪ **Attitude shift of new mother's Family**

Most mental health issues stem due to non-supportive partner and lack of support from family. Families in Rajasthan as reported by the healthcare providers usually are unaware of this and usually force the mother to get back into normal life as soon as possible creating pressure and unnecessary burden on the new mother's mind which is already going through hormonal changes and physical discomfort leading to postpartum issues.

Awareness schemes through media, newspapers, etc. can mitigate the situation more efficiently.

▪ **Strengthening Access, Enrolment, and Ground-Level Monitoring in Rural Areas for Divyang students**

The study highlights a continuous drop-in enrollment rate of female PwD category students in Rajasthan since 2017 (according to the AISHE report). Hence there is a need for strict and continuous monitoring of school enrolment and attendance of

female Divyang students. Schools in rural or urban areas should not be permitted to deny admission to any student on the basis of disability. The compliance with inclusive education (as per NEP 2020 guidelines) must be actively enforced through regular inspections and reporting mechanisms. Given the intersectionality faced by differently-abled girls in Rajasthan due to prevailing socio-cultural beliefs, targeted monitoring at the grassroots level is essential.

It can be achieved through incentive-based mechanisms where families receive material or welfare-linked benefits if differently-abled girls attend school regularly for an assigned number of days by the government.

If cases of persistent neglect or denial of education are found, the State may assume a protective and supervisory role to ensure the educational rights of the child.

▪ **Institutionalizing Skill-Based Education that generates Employability**

The findings indicate that academic education alone is not sufficient. To ensure long-term empowerment of differently-abled women, it is important that all schools incorporate skill-based education as a compulsory component of the curriculum. While such training should be universal, special emphasis must be placed on Divyang students, and within this group, on female students who face higher risks of dropout and economic dependence.

Skills should be such that it generates employment and income generation. It will not only enable students to secure livelihoods but also make the female empowered, even if formal education is discontinued after secondary or higher secondary levels. These skills may include typing and computer work, tailoring, pottery, carpentry, music and vocal training, dancing, acting, fashion designing, rangoli, mehndi and other craft work, or other locally relevant vocations. Skill certification linked to recognized employment pathways would significantly enhance economic independence and social inclusion for Divyang women.

- **Strengthening Inclusive Education through Special Educators' Job Security**

Although inclusive education remains a challenging policy initiative, the study emphasizes that it must be targeted more systematically rather than selectively. Currently, special educators are appointed only when schools enroll differently-abled students (a certain number of admissions) leading to employment instability. This approach discourages qualified individuals from entering or remaining in the profession. Hence, to ensure continuity of dedicated expert educators, their job security should be targeted.

It is recommended that every school, irrespective of current enrolment patterns, appoint at least one qualified special educator. A stable cadre of special educators would not only improve educational outcomes for such students but also prepare institutions for future inclusion.

- **Ensuring Safety and Institutional Support for Divyang Girls**

The safety concerns emerged as a major barrier to declining rate of enrollment among Divyang female students. Special educators reported that girls with special needs are more vulnerable to harassment, abuse, and violence than regular students, particularly in residential and hostel-based settings. Any expansion of hostels or residential facilities must therefore be accompanied by robust security arrangements for both students and its female staff, gender-sensitive supervision, and strict accountability mechanisms.

- **Supporting the existing Independent Institutions**

Numerous special schools operated by private individuals and non-governmental organizations currently provide essential support to Divyang students. These institutions should be formally recognized and fairly funded by the government, subject to regulatory standards. Eligibility criteria could include maintaining a minimum number of enrolled students over a sustained period (may be introduced to ensure accountability and reduce fraudulent activity) while providing financial stability. Strengthening and regulating such existing institutions would expand educational access for students who require continuous and specialized support.

5.10. Contribution to Knowledge

- **Life-course perspective on women's mental health**

The study contributes to knowledge by providing a life-course, governance-based analysis of women's mental health in Rajasthan. This approach enhances the understanding that women's mental health is a continuous process. It demands unique attention, prevention and cure at different stage of life.

- **Mental health as a governance and administrative concern**

By integrating mental health issue with healthcare systems and administrative mechanisms of educational institutions, local and state bodies, this study contributes uniquely to the existing literature. It highlights how interdisciplinary study of psychology and administration can bring groundbreaking changes in Indian society.

- **Empirical evidence from Jaipur and Kota districts of Rajasthan**

These two districts remain under-represented in existing literature when it comes to comparative studies. Kota is heavily studied as the epicenter of mental health crisis. This study not only compares it with the Capital city of Kota district but also brings to light a new perspective that stress in adolescent students is equally significant in other educational hubs, if not more.

- **Providing unique perspectives**

This study provides perspectives of healthcare providers in Postpartum mental health study and educators perspectives in research on Divyang Females' education. It is unique because in the past, researches have mainly focused on the perspective of patients while studying for Postpartum depression and on administration while studying Divyang students' education. Although, patients provide personal narratives of their experience, healthcare providers provided a deeper, expert and unbiased opinion on the issue. And, special educators provided insights from their personal experience not only with the students but also with their parents because a teacher is the one who spends most time with the students and interacts with the parents, not the administration.

5.11. Limitations of the study

▪ **Geographical Scope of study**

This study was limited to only two districts of Rajasthan that is Jaipur and Kota districts only, due to time and budget constraints. To get a better understanding about the mental health of women in Rajasthan in general, this study could be done in more districts of Rajasthan.

▪ **Variables of Research**

Since the study was focused on ‘Women Empowerment’, it gathered data only from female adolescent. But to gather a comprehensive understanding of mental health in adolescents, data could be collected from male students as well.

For postpartum mental health, experience of mothers along with the healthcare providers would have provided a complete picture.

For the education of Divyang Female, interview with the parents of such children with the special educators would have provided an overall understanding of the ground reality.

▪ **Limited Respondents**

Data for Adolescent mental health was collected from 560 female respondents. Data for Postpartum mental health was collected from 52 healthcare providers. Data for Education of Divyang Women was collected from 40 special educators. The respondents were limited due to many reasons such as permission hurdles, time constraints, budget issues among other. A bigger sample size would have provided more space for generalizability.

5.12. Future Directions

▪ **Inter-state comparisons**

Comparison of mental health of adolescents can be done by comparing students from two states such as Rajasthan and a neighboring state or Rajasthan and a state where mental health of student is much better and then compare the existing policies in that state with Rajasthan. Similar studies can be done for Postpartum mental health and education of Divyang female.

▪ **Independent Researches**

For **Adolescent Mental health**, interviews can be conducted with parents, teachers from schools as well as coaching institutes along with the students. This will provide an in-depth knowledge of the existing mental health crisis.

Similarly, for **postpartum mental health**, an in-depth study could be done exclusively by interviewing not just the healthcare providers but also with ASHA workers or patients who have either gone through the issue or going through it with due permission.

Insights from parents of **Divyang students** along with special educators will provide a holistic picture of their current situation and offer better solution. Moreover, in this study the focus was on female students only. It could be extended to all the genders.

Research is a continuous and never-ending process, built upon the vast body of knowledge generated by earlier scholars. The present study represents a modest attempt to address identified gaps within this ever-expanding bridge, with the hope that its findings will contribute meaningfully to existing scholarship and serve as a foundation for future research.

In hope for a more equitable, inclusive and dignified future for women...

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Questionnaire

QUESTIONNAIRE

- **For Chapter 2: Adolescent Mental Health**

Before Proceeding (Informed Consent)

By completing and submitting this questionnaire, you voluntarily consent to participate in this research study on mental health. Please note that while personal data will not be collected, any information provided will be treated with the utmost confidentiality and used solely for research purposes. Participation in this study is entirely voluntary, and you reserve the right to withdraw at any time without any consequences.

If you have any questions or concerns regarding this study, please feel free to contact the researcher.

Consent

☐ **I Consent**

SECTION I: DEMOGRAPHIC DETAILS

1. Age
 - ☐ 15–17 years
 - ☐ 17–19 years
2. Gender
 - ☐ Female
 - ☐ Male
3. Number of siblings (excluding yourself)
 - ☐ 0
 - ☐ 1
 - ☐ 2
 - ☐ 3
 - ☐ More than 3

4. City of current residence
- ☐ Jaipur
 - ☐ Kota
 - ☐ Other (please specify): _____
5. Current place of residence
- ☐ At home (with parents)
 - ☐ With a relative
 - ☐ Away from home (Hostel / PG / Apartment, etc.)
6. Duration of stay in current residence
- ☐ Less than 6 months
 - ☐ 6 months to one year
 - ☐ More than one year
7. Current educational institution
- ☐ School
 - ☐ College
 - ☐ Coaching Institute
 - ☐ Other (please specify): _____
8. I am answering the following questions for my:
- ☐ School
 - ☐ College
 - ☐ Coaching Institute
9. Distance of educational institution from place of residence
- ☐ Less than 1 km
 - ☐ 1–3 km
 - ☐ 3–6 km
 - ☐ 6–9 km
 - ☐ More than 9 km

SECTION II: ACADEMIC STRESS

10. On a scale of 1–5 (1 = least stressed; 5 = most stressed), how stressed do you feel about your academic performance?
- ☐ 1
 - ☐ 2
 - ☐ 3
 - ☐ 4
 - ☐ 5
11. Do you feel that being away from home affects your academic stress?
- ☐ Yes
 - ☐ No
12. How often do you receive academic guidance from your teachers?
- ☐ Daily
 - ☐ Weekly
 - ☐ Monthly
 - ☐ Rarely
 - ☐ Never
13. How helpful do you find the academic guidance provided by your teachers?
- ☐ Always helpful
 - ☐ Mostly helpful
 - ☐ Sometimes helpful
 - ☐ Rarely helpful
 - ☐ Never helpful
14. Do you find the academic environment supportive and inclusive as a woman?
- ☐ Yes
 - ☐ No

SECTION III: SOCIAL AND EMOTIONAL SUPPORT

15. Does your institution provide career counselling?
- ☐ Yes
- ☐ No
16. How frequently do you communicate with your family?
- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Rarely
17. How supported do you feel by the local administration (Hostel authorities / College administration / Coaching administration, etc.) with respect to your safety and security?
- ☐ Very supported
- ☐ Somewhat supported
- ☐ Neutral
- ☐ Not at all supported

SECTION IV: MENTAL HEALTH AND WELL-BEING

18. How often do you feel homesickness?
- ☐ Very often
- ☐ Often
- ☐ Occasionally
- ☐ Never
19. How often have you felt overwhelmed in the past year (with respect to career/studies)?
- ☐ Almost every day
- ☐ Almost every week
- ☐ Almost every month
- ☐ Very rarely (once in six months or so)
- ☐ Never

20. Have you experienced any of the following in the past month? (Select all that apply)
- ☐ Persistent sadness or hopelessness
 - ☐ Anxiety or excessive worry
 - ☐ Panic attacks
 - ☐ Loneliness
 - ☐ Suicidal thoughts
 - ☐ None of the above
21. Have you sought help for mental health issues in the past?
- ☐ Yes
 - ☐ No
22. If yes, what resources did you use? (Select all that apply)
- ☐ Therapy or counselling services
 - ☐ Medication prescribed by a doctor
 - ☐ Online resources or self-help materials
 - ☐ None of the above
 - ☐ Not applicable
23. If no, what barriers have prevented you from seeking help? (Select all that apply)
- ☐ Stigma or shame
 - ☐ Lack of access to resources
 - ☐ Financial barriers
 - ☐ Lack of time
 - ☐ Belief that the issue will resolve on its own
 - ☐ Not applicable

SECTION V: ADMINISTRATIVE SUPPORT

24. How satisfied are you with the mental health support services provided by your institution?
- ☐ Very satisfied
 - ☐ Somewhat satisfied
 - ☐ Neutral
 - ☐ Not satisfied
25. Do you feel your mental health needs are adequately understood and addressed by the administration (State Government / Educational Institutions, etc.) as a woman?
- ☐ Yes
 - ☐ No
26. Are you aware of any psychological counselling centres in your current residence provided by local administration?
- ☐ Yes (please specify): _____
 - ☐ No

SECTION VI: SECURITY AND MODE OF CONVEYANCE

27. Are you aware of any ongoing schemes or policies provided by the State or Local Government to address career stress or mental health issues faced by female students in Rajasthan?
- ☐ Yes (please specify): _____
 - ☐ No
28. How secure do you feel on your educational institution's campus?
- ☐ Very secure
 - ☐ Somewhat secure
 - ☐ Neutral
 - ☐ Not secure

29. What is your primary mode of conveyance to and from your educational institution?
- ☐ Walking
 - ☐ Cycling
 - ☐ Public transport (Bus / Auto-rickshaw, etc.)
 - ☐ Institution-provided transport
30. When do you usually leave for classes?
- ☐ Mostly before 5 AM
 - ☐ Mostly between 5–8 AM
 - ☐ After 8 AM
 - ☐ Evening classes
 - ☐ Time varies every day
31. When do you usually return after classes?
- ☐ Before 7 PM
 - ☐ Between 7–8 PM
 - ☐ Between 8–9 PM
 - ☐ After 9 PM
 - ☐ Time varies every day
32. Based on the above, do you feel safe while commuting to and from your institution?
- ☐ Yes
 - ☐ No
33. Do you feel that your institution provides adequate security measures for female students?
- ☐ Yes
 - ☐ No
 - ☐ Maybe, but I am unaware of the same

34. How often do you study in the library?
- ☐ Daily
 - ☐ Regularly (more than 4 days a week)
 - ☐ Occasionally (once a week)
 - ☐ Rarely (once a month)
 - ☐ Never
35. How safe do you feel while studying in the library?
- ☐ Very safe
 - ☐ Somewhat safe
 - ☐ Neutral
 - ☐ Unsafe (please specify reason): _____

SECTION VII: OPEN-ENDED QUESTIONS

(Please feel free to express your views.)

36. What additional security measures in the following places would make you feel safer as a woman?
- a) educational institution campus
 - b) During commute
 - c) Library
 - d) Place of residence
37. What do you think are the biggest challenges to your mental health as a female student (studying from home/away from home)?
38. What do you expect from the Central, State, and Local administration to improve support for young women like yourself?

- **For Chapter 3: Postpartum Mental Health**

SECTION I: RISK FACTORS FOR POSTPARTUM DEPRESSION

1. Which factors are identified as significant risk factors for postpartum depression among women in Rajasthan?

(Select all that apply)

- ☐ Female child born in the current pregnancy
- ☐ Financial difficulties
- ☐ Past history of psychiatric illness, anxiety, or low mood
- ☐ Low maternal education
- ☐ Childcare-related stressors
- ☐ Congenitally malformed infant
- ☐ Other (please specify): _____

2. Based on your clinical experience, which family-related factors do you observe as most associated with postpartum depression (PPD)?

(Select all that apply)

- ☐ Living in a joint family
- ☐ Living in a nuclear family
- ☐ Lack of partner support
- ☐ Lack of family support
- ☐ Marital discord
- ☐ Partner alcoholism
- ☐ Other (please specify): _____

3. What delivery-related or childbirth factors do you find most associated with postpartum depression (PPD)?

(Select all that apply)

- ☐ Cesarean delivery
- ☐ Normal vaginal delivery
- ☐ Unplanned pregnancy
- ☐ Multiple pregnancies
- ☐ Other (please specify): _____

4. How do societal or cultural expectations influence new mothers' mental health, in your observation?

(Select all that apply)

- ☐ Pressure to return to normal roles quickly
- ☐ Expectation to prioritize child over personal health
- ☐ Gender preference pressure
- ☐ Other (please specify): _____

5. How do cultural beliefs in Rajasthan influence the recognition and treatment of postpartum depression among women?

- ☐ They significantly hinder recognition and treatment
- ☐ They somewhat influence recognition and treatment
- ☐ They have little to no impact
- ☐ Not sure

SECTION II: DIAGNOSIS AND PREVALENCE

6. On average, what percentage of women in Rajasthan, are clinically diagnosed with postpartum depression (PPD) per 1,000 births?

- ☐ 0–10%
- ☐ 10–20%
- ☐ 20–30%
- ☐ 30–40%
- ☐ 40–50%
- ☐ 50–60%
- ☐ Above 60%
- ☐ No such data is available

SECTION III: BARRIERS AND MANAGEMENT

7. What are the common barriers to effective management of postpartum depression in peripheral healthcare facilities in Rajasthan?

(Select all that apply)

- ☐ High patient-to-provider ratio
- ☐ Limited availability of mental health professionals
- ☐ Lack of awareness among mothers
- ☐ Fear of stigma among patients' families
- ☐ Inadequate maternity leave policies
- ☐ All of the above
- ☐ Other (please specify): _____

SECTION IV: ACCESSIBILITY AND USE OF SERVICES

8. Are mothers aware of mental health services provided in healthcare facilities in Rajasthan?

- ☐ Yes
- ☐ No
- ☐ I don't know

9. How aware do you think the general public in Rajasthan is about postpartum depression and its symptoms?

- ☐ Very aware
- ☐ Somewhat aware
- ☐ Not very aware
- ☐ Not at all aware

10. What percentage of mothers seek professional help for postpartum depression?

- ☐ Less than 10%
- ☐ 10–20%
- ☐ More than 20%
- ☐ Other (please specify): _____

11. Which types of support systems do you believe are most beneficial for new mothers in Rajasthan experiencing postpartum depression?

(Select all that apply)

- ☐ Support from extended family
- ☐ Local peer support groups
- ☐ Access to professional mental health services
- ☐ Community outreach programs (e.g., ASHA workers)
- ☐ None of the above
- ☐ Other (please specify): _____

SECTION V: EDUCATIONAL FACTORS

12. According to your clinical experience and available data, which educational level of women is most commonly associated with a higher prevalence of postpartum depression (PPD)?

- ☐ No formal education
- ☐ Primary education
- ☐ Secondary education
- ☐ Higher education (undergraduate and above)
- ☐ Postgraduate education or above
- ☐ Similar prevalence across all educational levels

SECTION VI: INITIATIVES AND INTERVENTIONS

13. What role do healthcare providers play in addressing postpartum depression among mothers in Rajasthan?

(Select all that apply)

- ☐ Diagnosing the condition
- ☐ Providing emotional support and referrals to mental health services
- ☐ Focusing solely on physical health
- ☐ Providing practical support through problem-solving
- ☐ Using group psychotherapy techniques

- ☐ Identifying depressive thoughts
 - ☐ Applying behavioral modification techniques
 - ☐ Assisting with decision-making
 - ☐ Implementing effective communication strategies
 - ☐ Building personal connections with new mothers
 - ☐ Other (please specify): _____
14. What initiatives are being taken by the administration or State Government to address postpartum mental health for new mothers in Rajasthan?
- ☐ Specialized training for healthcare providers
 - ☐ Integrating mental health screening in routine maternal health visits
 - ☐ Collaboration between hospitals, NGOs, and ASHA workers
 - ☐ No such initiatives are currently being taken
 - ☐ Other (please specify): _____

SECTION VII: POLICY AND GOVERNANCE FACTORS

15. Which existing Central Government-initiated schemes, public policies, or programmes do you believe have an impact on maternal mental health?
(Select all that apply)
- ☐ Maternity leave policies
 - ☐ Mental Healthcare Act, 2017
 - ☐ District Mental Health Programme (DMHP)
 - ☐ Community support programmes (ASHA workers, ANMs, etc.)
 - ☐ National Mental Health Programme (NMHP)
 - ☐ Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA)
 - ☐ None of the above
16. How effective do you think State Government or Local Government initiatives are in promoting mental health awareness among new mothers?
- ☐ Very effective
 - ☐ Somewhat effective

- ☐ Not effective
- ☐ No initiatives in place

SECTION VIII: BROADER PERSPECTIVE

17. Do you consider postpartum depression to be a disease of modern civilization?

- ☐ Yes
- ☐ No

18. What long-term effects do you observe in mothers in Rajasthan who have experienced postpartum depression?

(Select all that apply)

- ☐ Impact on mother–child bonding
- ☐ Relationship issues with partner or family members
- ☐ Ongoing mental health challenges
- ☐ Changes in parenting style
- ☐ No noticeable long-term effects
- ☐ Other (please specify): _____

19. What additional resources or policies do you think would be effective in supporting mothers with postpartum depression?

• **For Chapter 4: Education for Divyang Women**

Demographics

1. Name (Optional): _____
2. Age:
 - Below 25
 - 25–35
 - 36–45
 - 46–55
 - Above 55
3. Gender:
 - Male

- Female
 - Other
4. Educational Qualification:
- General B.Ed.
 - Special B.Ed. (Specify specialization): _____
 - Other (Please specify): _____
5. Years of Teaching Experience:
- Less than 2 years
 - 2–5 years
 - 6–10 years
 - 11–15 years
 - More than 15 years
6. Type of Institution:
- Government school (Inclusive)
 - Government school (Exclusive for differently-abled students)
 - Private school (Inclusive)
 - Private school (Exclusive for differently-abled students)
 - Special Education Center/NGO
 - Other (Please specify): _____
7. Have you received any formal training on inclusive education?
- Yes
 - No
8. If yes, what kind of training have you received?
- In-service teacher training
 - Certification course in special education
 - Workshop/seminar participation
 - Other (Please specify): _____

Section 1: Barriers to Education

Economic Barriers

9. What is the primary economic barrier faced by girls with disabilities in accessing education?
- Lack of transportation facilities
 - High costs of disability-related equipment
 - Lack of safe hostels for female differently-abled students
 - School fees for special schools
 - Other (Please specify)

Attitudinal Barriers

10. How do family and societal attitudes impact the education of girls with disabilities?
- Families show excessive sympathy, undermining confidence
 - Families feel shame in taking differently-abled children out in public, hindering their social skills
 - Society does not provide strong support for the education of disabled girls
 - Families are overly concerned about the safety of their female child, especially if she is differently abled

Societal Barriers

11. Which societal issue contributes most to the under-education of girls with disabilities?
- Gender preference for educating boys
 - Orthodox beliefs about the purpose of educating a girl child, which are amplified when it comes to females with disabilities
 - Lack of community support systems for disabled individuals
 - Other (Please specify)

Physical Barriers

12. What is a significant physical barrier preventing girls with disabilities from attending school?
- Inaccessible school infrastructure
 - Lack of trained teachers
 - Proximity of schools to their homes
 - Absence of schools for differently-abled students in rural areas

Section 2: Policy Awareness & Implementation

Effectiveness of Sugamya Bharat Abhiyaan

13. How effective is the Sugamya Bharat Abhiyaan for female differently-abled students?
- Very effective
 - Somewhat effective
 - Not effective
 - There should be gender-specific facilities for differently-abled students in government schemes

Awareness of Government Policies

14. Are you aware of the specific provisions for the education of differently-abled female students under the Rights of Persons with Disabilities (RPwD) Act, 2016 and other government initiatives?
- Yes, I am well aware
 - Somewhat aware but need more information
 - Not aware

National Education Policy (NEP) 2020 and Inclusive Education

15. The National Education Policy (NEP) 2020 promotes inclusive education. What are your views on this?
- Teaching regular students alongside students with special needs is impossible
 - Teaching both categories of students will promote a sense of brotherhood; it's a good initiative

- Teaching them together may undermine the confidence of differently-abled students
- If taught together, differently-abled students should have a separate special setting rather than being seated together
- An exclusive setting for such students is best and should continue
- Other (Please specify)

Section 3: Institutional Implementation & Safety

Barrier-Free Environment in Schools

16. The Ministry of Education has instructed Centrally Funded Educational Institutions to ensure a barrier-free environment. Which of the following provisions exist in your institution? (Select all that apply.)

- Ramps
- Rails
- Lifts
- Adapted toilets for wheelchair users
- Braille signage
- Auditory signals
- Tactile flooring
- None of these
- I am unsure

Safety Concerns for Differently-Abled Female Students

17. Have you or someone you know faced safety concerns while accessing education as a female differently-abled student?

- Yes
- No

18. What is the most critical safety concern for differently-abled female students?

- Lack of secure hostels
- Inadequate transport facilities
- Lack of female support staff in educational institutions
- Increased vulnerability to harassment or discrimination
- Other (Please specify)

19. There should be specific provisions for the education and safety of female differently-abled students.
- Strongly agree (The need for safety for female students, especially differently-abled ones, is a major concern)
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree (Because disability affects both men and women equally; there is no difference)

Section 4: Higher Education & Declining Enrolment (AISHE Report - Rajasthan)

Declining Enrolment of Female PwD Students in Higher Education

20. According to the All India Survey on Higher Education (AISHE) Report, the enrolment of female PwD students in higher education has been consistently declining in Rajasthan. What do you think is the main reason for this?
- Lack of accessibility in higher education institutions
 - Financial constraints and limited scholarships for female PwD students
 - Societal norms discouraging higher education for disabled women
 - Fear of safety and lack of secure accommodations for differently-abled women
 - Limited awareness and guidance regarding opportunities for PwD in higher education

Effectiveness of Government Schemes

21. Which government schemes are working effectively at the grassroots level for the education and inclusion of female differently-abled students? (Select all that apply.)
- Sugamya Bharat Abhiyaan
 - Initiatives taken by the Ministry of Education
 - Rights of Persons with Disabilities (RPwD) Act, 2016
 - Other (Please specify)
 - No schemes or policies are implemented as effectively as they should be

Section 5: Open-Ended Insights

Suggested Improvements

22. What is the single biggest change that could improve the education and safety of differently-abled female students in Rajasthan?
(Open-ended response)

Annexures

ANNEXURES

ANNEXURE 1

Table 15. State-wise Enrolment in PWD and Minority Community

Sl. No.	State/UTs	Persons with Disability			Muslim			Other Minority Communities		
		Male	Female	Total	Male	Female	Total	Male	Female	Total
1	2	3	4	5	6	7	8	9	10	11
1	Andaman and Nicobar Islands	15	10	25	207	323	530	416	678	1094
2	Andhra Pradesh	1832	1374	3206	32307	23793	56100	2939	3530	6469
3	Arunachal Pradesh	26	13	39	70	50	120	1409	1358	2767
4	Assam	528	354	882	45324	42480	87804	4268	4394	8662
5	Bihar	1596	589	2185	74955	67841	142796	908	847	1755
6	Chandigarh	78	49	127	270	214	484	2448	2503	4951
7	Chhattisgarh	284	171	455	2233	2849	5082	1800	3011	4811
8	Dadra and Nagar Haveli	4	5	9	27	31	58	21	45	66
9	Daman and Diu		1	1	89	73	162	10	10	20
10	Delhi	4714	3255	7969	15982	7600	23582	4869	5595	10464
11	Goa	35	25	60	1038	1118	2156	3169	4891	8060
12	Gujarat	1081	744	1825	19839	15556	35395	5550	4544	10094
13	Haryana	419	350	769	5702	1905	7607	5967	6437	12404
14	Himachal Pradesh	213	77	290	913	489	1402	553	1190	1743
15	Jammu and Kashmir	286	180	466	72401	69561	141962	2325	3568	5893
16	Jharkhand	500	252	752	18085	18702	36787	5050	7315	12365
17	Karnataka	2098	1510	3608	61778	57689	119467	30409	40700	71109
18	Kerala	1388	1356	2744	63875	85316	149191	48606	68548	117154
19	Lakshadweep				56	182	238			
20	Madhya Pradesh	1781	1099	2880	22406	17062	39468	7038	8692	15730
21	Maharashtra	4935	2971	7906	79997	71393	151390	39357	42592	81949
22	Manipur	67	32	99	2548	2336	4884	3046	3126	6172
23	Meghalaya	35	30	65	891	588	1479	10951	12522	23473
24	Mizoram	14	14	28	58	10	68	11861	11377	23238
25	Nagaland	7	6	13	103	112	215	6551	7988	14539
26	Odisha	967	600	1567	5862	5236	11098	1645	1786	3431
27	Puducherry	122	83	205	1395	1060	2455	904	1794	2698
28	Punjab	499	335	834	6106	2324	8430	62604	82694	145298
29	Rajasthan	2528	2496	5024	22280	16276	38556	7776	10198	17974
30	Sikkim	6	1	7	70	36	106	258	709	967
31	Tamil Nadu	3356	2466	5822	68582	49215	117797	64975	82103	147078
32	Telangana	1617	1054	2671	58234	51006	109240	4286	5580	9866
33	Tripura	124	36	160	1052	840	1892	555	388	943
34	Uttar Pradesh	8531	8106	16637	135983	162990	298973	9186	9371	18557
35	Uttarakhand	304	96	400	5670	4230	9900	1404	1455	2859
36	West Bengal	2640	1947	4587	113100	117635	230735	5996	6978	12974
	All India	42630	31687	74317	939488	898121	1837609	359110	448517	807627

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Annexure 2

Table 15: State-wise Enrolment in PWD and Minority Community

Sl. No.	State/UTs	Persons with Disability			Muslim			Other Minority Communities		
		Male	Female	Total	Male	Female	Total	Male	Female	Total
1	2	3	4	5	6	7	8	9	10	11
1	Andaman and Nicobar Islands	20	17	37	263	376	639	339	670	1009
2	Andhra Pradesh	1597	928	2525	33309	25470	58779	4428	4406	8834
3	Arunachal Pradesh	19	9	28	94	42	136	1688	1199	2887
4	Assam	599	364	963	49869	47596	97465	6586	6696	13282
5	Bihar	3433	1987	5420	80401	71171	151572	1167	1448	2615
6	Chandigarh	163	73	236	324	228	552	1876	2310	4186
7	Chhattisgarh	350	360	710	2406	2716	5122	1766	3141	4907
8	Dadra and Nagar Haveli	8	6	14	48	44	92	8	248	256
9	Daman and Diu		1	1	79	69	148	9	28	37
10	Delhi	4998	3348	8346	15715	8632	24347	6164	7775	13939
11	Goa	46	23	69	1274	1351	2625	3843	5699	9542
12	Gujarat	1127	613	1740	20279	15773	36052	5221	4455	9676
13	Haryana	505	829	1334	7297	2787	10084	6152	6933	13085
14	Himachal Pradesh	226	83	309	1189	608	1797	1048	1404	2452
15	Jammu and Kashmir	660	1675	2335	81908	75806	157714	2675	3986	6661
16	Jharkhand	459	180	639	20388	20122	40510	5602	7056	12658
17	Karnataka	2310	1986	4296	65642	59894	125536	36255	45244	81499
18	Kerala	1807	1704	3511	67175	92073	159248	48761	68145	116906
19	Lakshadweep				64	246	310			
20	Madhya Pradesh	1763	1565	3328	20195	16562	36757	14070	11958	26028
21	Maharashtra	4400	3535	7935	78777	73589	152366	41535	43125	84660
22	Manipur	81	48	129	3047	2554	5601	1496	1623	3119
23	Meghalaya	110	182	292	1318	934	2252	10694	13278	23972
24	Mizoram	12	14	26	54	29	83	9675	8980	18655
25	Nagaland	9	15	24	89	115	204	8214	10155	18369
26	Odisha	1158	803	1961	5741	4600	10341	1779	1831	3610
27	Puducherry	158	99	257	1456	1197	2653	950	1894	2844
28	Punjab	559	523	1082	7526	3308	10834	68769	88929	157698
29	Rajasthan	2848	1864	4712	26100	18258	44358	7629	10011	17640
30	Sikkim	7	1	8	136	60	196	781	1346	2127
31	Tamil Nadu	5889	4310	10199	71882	51689	123571	72974	80926	153900
32	Telangana	1583	1120	2703	67314	62968	130282	5054	5350	10404
33	Tripura	165	66	231	1346	1002	2348	482	304	786
34	Uttar Pradesh	7790	7001	14791	142299	177217	319516	12012	11943	23955
35	Uttarakhand	879	969	1848	7135	5609	12744	1686	1722	3408
36	West Bengal	2474	1364	3838	111257	120913	232170	5758	6736	12494
	All India	48212	37665	85877	993396	965608	1959004	397146	470954	868100

Annexure 3

Table 15. State-wise Estimated Enrolment in PWD and Minority Communities

Sl. No.	State/Uts	Persons with Disability			Muslim			Other Minority Communities		
		Male	Female	Total	Male	Female	Total	Male	Female	Total
1	2	3	4	5	6	7	8	9	10	11
1	Andaman and Nicobar Islands	18	44	62	166	304	470	293	645	938
2	Andhra Pradesh	1683	982	2665	34050	27245	61295	3884	3745	7629
3	Arunachal Pradesh	9	5	14	91	59	150	2519	2250	4769
4	Assam	511	301	812	47608	45745	93353	6796	7109	13905
5	Bihar	1879	737	2616	83382	80567	163949	1111	840	1951
6	Chandigarh	245	86	331	414	273	687	2140	2582	4722
7	Chhattisgarh	353	171	524	2427	2957	5384	2134	3465	5599
8	Dadra and Nagar Haveli	13	9	22	38	39	77	7	275	282
9	Daman and Diu	2	1	3	91	63	154	5	27	32
10	Delhi	4850	3412	8262	16168	10307	26475	6191	7797	13988
11	Goa	33	26	59	1291	1443	2734	3412	5446	8858
12	Gujarat	1207	1130	2337	24664	19350	44014	6049	5647	11696
13	Haryana	499	215	714	9317	3560	12877	5012	6921	11933
14	Himachal Pradesh	246	123	369	1103	661	1764	1753	1531	3284
15	Jammu and Kashmir	334	262	596	89608	89068	178676	2447	3229	5676
16	Jharkhand	773	384	1157	21742	21834	43576	6150	6989	13139
17	Karnataka	2398	2204	4602	75198	69313	144511	38600	49170	87770
18	Kerala	1975	1735	3710	68848	97179	166027	51070	66907	117977
19	Ladakh				652	1302	1954	307	583	890
20	Lakshadweep				70	256	326			
21	Madhya Pradesh	1403	1039	2442	24366	19923	44289	12788	12749	25537
22	Maharashtra	4714	3083	7797	83037	83191	166228	46074	49948	96022
23	Manipur	88	80	168	3380	3099	6479	1977	2409	4386
24	Meghalaya	204	163	367	1177	901	2078	10928	13402	24330
25	Mizoram	15	8	23	48	22	70	8560	8270	16830
26	Nagaland	17	19	36	100	112	212	7118	8878	15996
27	Odisha	1358	736	2094	5614	4232	9846	1641	1918	3559
28	Puducherry	131	154	285	1637	1489	3126	1013	2025	3038
29	Punjab	427	311	738	9558	4226	13784	65018	77450	142468
30	Rajasthan	3442	6519	9961	25128	19055	44183	8366	10998	19364
31	Sikkim	8	4	12	96	50	146	223	502	725
32	Tamil Nadu	3464	7437	10901	72794	56771	129565	76670	87694	164364
33	Telangana	1468	1472	2940	62229	59689	121918	3744	5161	8905
34	Tripura	290	74	364	1233	882	2115	300	188	488
35	Uttar Pradesh	9356	8694	18050	158790	198886	357676	13009	14124	27133
36	Uttarakhand	2009	2200	4209	8380	6979	15359	1864	1927	3791
37	West Bengal	2408	1181	3589	111879	123454	235333	5575	10201	15776
	All India	47830	45001	92831	1046374	1054486	2100860	404748	483002	887750

Annexure 4

Table 15. State-wise Estimated Enrolmen in PWD and Minority Communities

Sl No	State	Persons with Disability			Muslim			Other Minority Communities			EWS		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
1	2	3	4	5	6	7	8	9	10	11	12	13	14
1	Andaman and Nicobar Islands	22	34	56	255	363	618	401	731	1132	51	37	88
2	Andhra Pradesh	1659	957	2616	28338	23313	51651	5727	4301	10028	15650	14068	29718
3	Arunachal Pradesh	22	10	32	53	40	93	1849	1292	3141	111	74	185
4	Assam	644	316	960	44845	43084	87929	6791	6571	13362	8496	8916	17412
5	Bihar	3410	2236	5646	78713	75028	153741	1222	1658	2880	16533	12612	29145
6	Chandigarh	231	86	317	327	376	703	2072	3190	5262	832	631	1463
7	Chhattisgarh	344	132	476	2017	2676	4693	1885	3038	4923	1398	1143	2541
8	Delhi	2984	1442	4426	11900	9304	21204	4865	6211	11076	14261	8932	23193
9	Goa	34	13	47	1378	1520	2898	3630	5449	9079	197	98	295
10	Gujarat	1143	628	1771	18170	14935	33105	5561	5709	11270	23494	16279	39773
11	Haryana	646	447	1093	7423	3022	10445	4769	6919	11688	5867	4413	10280
12	Himachal Pradesh	192	91	283	616	560	1176	1141	1354	2495	1196	1203	2399
13	Jammu and Kashmir	297	291	588	65193	66149	131342	2465	3328	5793	2500	3192	5692
14	Jharkhand	546	225	771	17069	17244	34313	4916	6884	11800	3010	1700	4710
15	Karnataka	2665	1830	4495	72487	65871	138358	36086	45593	81679	15920	35128	51048
16	Kerala	2103	1888	3991	68170	102759	170929	51334	63552	114886	6189	10363	16552
17	Ladakh	0	0	0	679	1341	2020	226	564	790	0	0	0
18	Lakshadweep	0	0	0	70	256	326	0	0	0	0	0	0
19	Madhya Pradesh	1886	708	2594	20995	20432	41427	8968	9814	18782	7293	5162	12455
20	Maharashtra	3949	2214	6163	79148	71656	150804	42054	39620	81674	29953	21698	51651
21	Manipur	123	110	233	1904	2526	4430	2519	2630	5149	115	59	174
22	Meghalaya	188	139	327	1150	912	2062	13119	17005	30124	207	136	343
23	Mizoram	14	13	27	50	28	78	9747	10304	20051	18	8	26
24	Nagaland	3	5	8	113	144	257	4719	6615	11334	173	60	233
25	Odisha	1041	693	1734	4728	3759	8487	1562	1548	3110	7257	7991	15248
26	Puducherry	120	202	322	1202	1139	2341	851	1866	2717	176	122	298
27	Punjab	318	255	573	11803	4682	16485	53417	65836	119253	5937	3337	9274
28	Rajasthan	4579	1729	6308	24356	18634	42990	8595	11274	19869	14756	13941	28697
29	Sikkim	7	1	8	102	45	147	572	784	1356	46	41	87
30	Tamil Nadu	2831	2038	4869	65103	49869	114972	76594	85648	162242	20557	18667	39224
31	Telangana	1761	1343	3104	65893	63061	128954	3769	5896	9665	7201	7214	14415
32	The Dadra and Nagar Haveli and Daman and Diu	10	10	20	135	132	267	10	297	307	45	39	84
33	Tripura	90	47	137	656	691	1347	333	295	628	355	166	521
34	Uttar Pradesh	9484	5519	15003	137654	161657	299311	10725	12255	22980	23733	16288	40021
35	Uttarakhand	1497	1458	2955	11100	12540	23640	1889	2369	4258	1970	1234	3204
36	West Bengal	4491	2591	7082	110860	127310	238170	7381	7702	15083	8753	8574	17327
	All India	49334	29701	79035	954655	967058	1921713	381764	448102	829866	244250	223526	467776

Annexure 5

Table 15. State-wise Enrolment in PWD and Minority Communities (including Estimation)

Sl No	States/UTs	Persons with Disability			Muslim			Other Minority Communities			EWS		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
1	2	3	4	5	6	7	8	9	10	11	12	13	14
1	Andaman and Nicobar Islands	27	39	66	239	370	609	402	743	1145	49	63	112
2	Andhra Pradesh	1361	1167	2528	32718	23726	56444	4241	4420	8661	20391	19050	39441
3	Arunachal Pradesh	24	28	52	65	42	107	2470	1673	4143	221	124	345
4	Assam	429	232	661	44047	40761	84808	5841	5894	11735	12932	14272	27204
5	Bihar	2732	1209	4021	93896	78785	172681	3879	4058	7937	24859	18422	43281
6	Chandigarh	287	151	438	321	371	692	1726	2842	4568	1178	1737	2915
7	Chhattisgarh	799	411	1210	2348	2765	5113	2911	4418	7329	2144	2520	4664
8	Delhi	4073	2328	6401	15489	12793	28282	5033	5155	10188	19811	13540	33351
9	Goa	460	144	604	1531	1553	3084	4446	5734	10180	475	405	880
10	Gujarat	2885	2156	5041	19387	16606	35993	6945	7190	14135	35817	24763	60580
11	Haryana	798	483	1281	7869	3092	10961	5629	6447	12076	9445	6252	15697
12	Himachal Pradesh	335	170	505	746	568	1314	1028	1104	2132	2551	2085	4636
13	Jammu and Kashmir	514	221	735	63796	74346	138142	2323	2997	5320	3604	3970	7574
14	Jharkhand	881	294	1175	19532	18668	38200	4976	7421	12397	5837	3365	9202
15	Karnataka	3397	2660	6057	78638	68611	147249	42716	51895	94611	26058	26549	52607
16	Kerala	2843	2472	5315	76375	110983	187358	55951	65238	121189	10383	16815	27198
17	Ladakh	1		1	421	727	1148	451	886	1337			
18	Lakshadweep				14	74	88						
19	Madhya Pradesh	2277	1778	4055	22617	16588	39205	10826	9856	20682	11964	6875	18839
20	Maharashtra	4955	3216	8171	79193	75322	154515	54185	52601	106786	45510	32387	77897
21	Manipur	85	91	176	964	1000	1964	1080	2702	3782	133	62	195
22	Meghalaya	477	508	1065	1324	795	2119	6253	8492	14745	240	214	454
23	Mizoram	14	17	31	77	53	130	9504	9709	19213	62	37	99
24	Nagaland	14	7	21	112	141	253	8303	9698	18001	43	260	303
25	Odisha	1214	806	2020	4412	4097	8509	2468	2478	4946	13816	9796	23612
26	Paducherry	94	193	287	1565	1705	3270	1035	2012	3047	233	150	383
27	Punjab	599	468	1067	14277	5640	19917	60736	69745	130481	6712	5732	12444
28	Rajasthan	3563	1661	5224	26212	20199	46411	9186	10366	19552	24977	25717	50694
29	Sikkim	17	3	20	111	51	162	889	1368	2257	140	139	279
30	Tamil Nadu	4141	4670	8811	64355	51335	115690	82102	86618	168720	15193	14612	29805
31	Telangana	2371	1618	3989	64775	56543	121318	4036	5531	9567	10800	10724	21524
32	The Dadra and Nagar Haveli and Daman and Diu	12	8	20	108	120	228	19	333	352	74	79	153
33	Tripura	157	54	211	1796	1206	3002	219	227	446	445	227	672
34	Uttar Pradesh	6006	5858	11864	157372	169447	326819	13717	15277	28994	33485	24019	57504
35	Uttarakhand	934	730	1664	7998	8838	16836	1998	2169	4167	3750	2644	6394
36	West Bengal	2597	1364	3961	164066	171346	335412	9901	10437	20338	11202	14421	25623
	All India	51373	37375	88748	1068766	1039267	2108033	427425	477734	905159	354534	302027	656561

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Women Empowerment and Inclusive Education: Addressing the Challenges Faced by Differently-Abled Women in Jaipur for Viksit Bharat @2047

Mrs. Vasudha Pandey*

ABSTRACT

This study delves into the crucial role of women's participation in the vision of Viksit Bharat @2047, with a particular focus on the education of differently-abled women in Jaipur. By conducting interviews with special educators and analyzing existing policies and programs, this research aims to highlight the current state of educational opportunities and challenges faced by differently-abled women in the region. The insights gathered from special educators provide a ground-level perspective on the effectiveness of current initiatives and identify gaps that need addressing. Furthermore, the analysis of existing policies and programs sheds light on their impact and efficacy in fostering inclusive education.

A significant aspect of this study is its focus on the inclusion of marginalized groups, recognizing that true inclusivity and proper development can only be achieved when all segments of society are given equal opportunities. Ensuring that differently-abled women have access to quality education and support systems is essential for their empowerment and integration into mainstream society. Addressing the needs of marginalized groups is crucial for India to genuinely aspire to and achieve the title of a developed nation.

This research emphasizes the importance of tailored educational strategies and policy enhancements to ensure that differently-abled women are not left behind in India's march towards development. The findings are expected to inform policymakers, educators, and stakeholders about the necessary steps to

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create an inclusive and empowering educational environment for differently-abled women, thereby contributing to the broader goal of a developed India by 2047.

Keywords: Women Empowerment, Inclusive Education, Differently-Abled Women, Special Educators, Educational Policies, Viksit Bharat @2047

Viksit Bharat @2047 envisions India becoming a fully developed country by 2047, coinciding with the centenary of its independence. This vision encompasses a holistic approach to development, emphasizing robust economic growth, social advancement, sustainable environmental practices, and exemplary governance.

Women's education is crucial as it empowers them to break free from societal norms, gain financial independence, and contribute significantly to their communities. Educated women are more likely to participate in the workforce, make informed health decisions, and advocate for their rights, leading to overall societal progress (Rana, 2022). For differently-abled women, education is even more vital. It provides them with the skills and confidence needed to overcome additional barriers they face due to both gender and disability. Educating differently-abled women ensures they can achieve economic independence, reduce their vulnerability to exploitation, and actively participate in social and political spheres, fostering a more inclusive society. (UNICEF, 2022)

Inclusion and empowerment of differently-abled women in education is crucial for several reasons.

Importance of Inclusion in Education

Equal Opportunities: Differently-abled women often face multiple layers of discrimination based on both gender and disability. Ensuring their inclusion in education helps to level the playing field, providing them with the same opportunities as others to learn, grow, and contribute to society. (Nair, 2023)

Economic Independence: Education is a key factor in achieving economic independence. By providing differently-abled women with access to education, we enable them to acquire skills and knowledge that can lead to better job opportunities and financial stability. Educated differently-abled women can participate more effectively in the workforce, contributing to economic growth and reducing dependency ratios.

Social Integration: Inclusive education promotes social integration by bringing together students of all abilities. This helps to break down stereotypes and build a more inclusive and tolerant society. (Nair, 2023)

Improved Quality of Life: Education empowers differently-abled women to make informed decisions about their lives, health, and well-being. It also enhances their self-esteem and confidence. (Lawrence & Belinda, 2019)

IMPORTANCE IN RELATION TO THE CONSTITUTION

Fundamental Rights: The Constitution of India guarantees the right to equality (Article 14), the right to non-discrimination (Article 15), and the right to education (Article 21A).

Directive Principles of State Policy: The Directive Principles of State Policy (Article 41) emphasize the state's responsibility to provide education and assistance to differently-abled individuals

Promoting Social Justice: The Constitution aims to promote social justice and equality. Inclusive education for differently-abled women is a step towards achieving these goals by addressing historical injustices and ensuring that all citizens have the opportunity to participate fully in society.

By focusing on **Jaipur**, a city with significant socio-economic diversity, this research aims to identify the specific challenges and opportunities for differently-abled women in education. This will help in formulating targeted strategies to ensure their inclusion in the developmental agenda, ultimately contributing to a more equitable and just society.

REHABILITATION COUNCIL OF INDIA

The Rehabilitation Council of India (RCI) began as a registered society in 1986. In September 1992, Parliament enacted the RCI Act, transforming it into a Statutory Body on June 22, 1993. This Act was further amended in 2000 to broaden its scope. RCI's mandate includes regulating and monitoring services provided to persons with disabilities, standardizing educational syllabi, and maintaining a Central Rehabilitation Register of all qualified professionals and personnel in the fields of Rehabilitation and Special Education. Additionally, the Act enforces punitive measures against unqualified individuals who offer services to people with disabilities.

Rajasthan has more than 200 institutions that provide special education to or for individuals with different needs. In Jaipur itself there are more than 55 institutions that provide education to and for the differently abled students. Students are not refrained from taking admission in Central Schools (seats are reserved for students of PwD category). But, the enrolment is lesser for girl than boys (RCScE, 2024).

SPECIAL EDUCATORS

A special education teacher works with children of all ages who have cognitive, emotional, or physical disabilities. They may teach in specialized classrooms or resource centers exclusively for students with special needs, or they might assist in inclusive classrooms, supporting general education teachers. Their primary role is to provide personalized attention and employ unique strategies to help these students achieve their full potential.

Special education teachers often design Individualized Education Programs (IEPs) to establish goals and track student progress. They collaborate with other teachers and counselors to develop lesson plans and write reports. Additionally, they frequently communicate with parents to keep them informed about their child's development.

Samagra Shiksha Abhiyaan

The key points from the Inclusive Education Programmes under Samagra Shiksha that specifically address the needs of girls:

1. Stipend for Girls with Special Needs:

- The financial support for girls with special needs has been extended. Previously, only girls from classes IX to XII received a stipend under RMSA. Now, under Samagra Shiksha, this support is available for girls from classes I to XII. This aims to encourage their enrollment and ensure they stay in school. The stipend is provided via Direct Benefit Transfer.

2. Home-Based Education for Girls with Severe/Multiple Disabilities:

- The home-based education provision has been expanded to include children with severe or multiple disabilities up to class XII. This allows girls with significant disabilities to continue their education from home. In the 2018-19 academic year, this initiative supported 43,996 children with an allocation of Rs. 9.22 crore.

These points highlight the program's efforts to support the education of girls with special needs, ensuring they have access to the necessary resources and opportunities to complete their education.

METHODOLOGY

A couple of Special educators were interviewed with closed ended questions on Enhancing Educational Opportunities for Differently-Abled Women in Jaipur.

Questions targeted current facilities, required facilities, government support and initiatives.

Sampling Technique: Purposive Sampling was used to interview Special Educators.

FINDINGS AND DISCUSSION

The research revealed that while there are several policies in place, their implementation is inconsistent. Differently-abled women in Rajasthan face significant challenges, including:

- **Infrastructure:** Lack of accessible infrastructure in schools.
- **Resources:** Inadequate educational materials and support systems.
- **Training:** Insufficient training for educators on inclusive teaching practices.

Findings of the Research on Education for Differently-Abled Women in Jaipur Government Schools

1. Infrastructure and Accessibility:

- Many government schools in Jaipur have accessible classroom facilities, specialized teaching materials, and basic infrastructure. However, there is a significant need for improvements in special infrastructural facilities such as tactile pathways, roadmaps for classrooms and facilities for blind students, signage, and special washrooms for dwarf students.

2. Availability of Special Educators:

- Some Central Schools have special educators, but there is a notable shortage of special educators in most government schools.

3. Training and Assistive Technologies:

- Special educators interviewed emphasized the need for more specialized training programs to support differently-abled women. They also highlighted the necessity for more assistive technologies to aid these students.

4. Funding:

- Although the Samagra Shiksha Abhiyaan provides funding to different states and stipends, especially for girl children, special educators at the grassroots level believe that increased funding is needed to offer better educational facilities for differently-abled women.

5. Effectiveness of Government Policies:

- Special educators generally agree that current government policies are effective in supporting the education of differently-abled women. However, they acknowledge that there is considerable room for improvement.
- 6. **Community Awareness:**
 - There is a consensus among special educators on the importance of community awareness programs about the education of differently-abled women. These programs require special attention to be effective.
- 7. **Inclusive Curriculum Content:**
 - Special educators advocate for more inclusive curriculum content, such as braille textbooks for visually impaired students, simplified language for those with cognitive disabilities, and skill development programs. These enhancements are seen as crucial for improving student performance.

Key gaps (identified)

- **Policy Implementation:** Discrepancies between policy and practice.
- **Awareness:** Low awareness among communities about the rights and capabilities of differently-abled women.
- **Support Systems:** Need for more robust support systems, including counseling and career guidance.
- **Technical Assistance:** Require more facilities like Braille, Tactile Pathways, etc in school system.

The case studies of Cleves Primary School in London, the Sophie-Scholl-Schule in Gießen, and the Public School Padre Jerónimo in Madrid all showcase different approaches to inclusive education, emphasizing the importance of a supportive environment, diverse teaching methods, and the role of the community. Here are some key takeaways:

Cleves Primary School, London, UK

- **Inclusive Environment:** The school integrates students with high-level support needs, creating a learning environment that values diversity and inclusion.
- **Curriculum and Support:** The curriculum is designed to accommodate all students, with a strong focus on peer support and relationships.
- **Community and Partnerships:** There is active collaboration between staff, parents, and external agencies to support inclusive education.

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- **Ethos and Policy Implementation:** Cleves follows a borough-wide policy of inclusion, resulting in a unique school culture that supports all students.

SOPHIE-SCHOLL-SCHULE, GIESSEN, GERMANY

- **Acceptance of Heterogeneity:** The school's approach is based on recognizing and valuing the diversity of students.
- **Innovative Teaching Methods:** Lessons are tailored to the needs of each child, allowing all students to participate in learning.
- **Multi-professional Collaboration:** Teams of teachers, educators, and therapists work together to support students.
- **Parental Involvement:** Parents are deeply involved in school development, contributing to the school's inclusive culture.

PUBLIC SCHOOL PADRE JERÓNIMO, MADRID, SPAIN

- **Customized Curriculum:** The school adapts materials and teaching strategies to meet the needs of students with special educational needs (SEN).
- **Teacher Development:** There is ongoing teacher training to support inclusive practices.
- **Community Involvement:** The school emphasizes dialogue and collaboration among all stakeholders, including teachers, parents, and students.
- **Multi-disciplinary Coordination:** A system of coordination and record-keeping ensures that all students' progress is monitored and supported effectively.

These schools highlight how inclusive education can be successfully implemented by embracing diversity, fostering collaboration, and continuously adapting teaching methods to meet the needs of all students.

RECOMMENDATIONS

To achieve the vision of Viksit Bharat@2047, the following recommendations are proposed:

1. **Policy Implementation:** Strengthen the implementation of inclusive education policies with regular monitoring and evaluation.
2. **Infrastructure Development:** Invest in accessible infrastructure in all educational institutions for student's special needs.

3. **Teacher Training:** Provide comprehensive training for special educators on inclusive practices and the use of assistive technologies.
4. **Community Awareness:** Conduct awareness campaigns to change societal attitudes towards differently-abled women.
5. **Financial Aid:** Government must provide more financial aid for differently abled students.

CONCLUSION

This study highlights the vital role of inclusive education in empowering differently-abled women in Jaipur, aligning with the broader vision of Viksit Bharat @2047. While some government schools in Jaipur offer accessible classrooms and specialized teaching materials, there are still significant gaps in infrastructure, such as the need for tactile pathways and specialized signage for blind and dwarf students.

The effectiveness of inclusive education is further hindered by the shortage of special educators in most schools. These educators emphasize the need for more specialized training programs and assistive technologies to better support differently-abled women.

Despite the funding from Samagra Shiksha Abhiyaan, there is a consensus that increased financial support is essential to improve educational facilities. Special educators generally agree that while current government policies are effective, their implementation needs improvement. Community awareness programs are crucial to fostering a supportive environment for the education of differently-abled women.

The research findings stress the importance of a more inclusive curriculum, incorporating materials like braille textbooks and simplified content for students with cognitive disabilities. Addressing these gaps will significantly contribute to empowering differently-abled women, ensuring their full participation in society, and advancing the goal of a developed India by 2047.

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Unveiling the Gap: The Lack of Women-Centric Mental Health Interventions in Rajasthan

Dr. Anil Kumar Pareek* and Vasudha Pandey**

ABSTRACT

This study examines the current state of mental health provisions and policies in Rajasthan, India, with a focus on women's mental health. The analysis reveals significant gaps in coverage, availability of services, human resources, and treatment provision for women's mental health. The study emphasizes the need for gender-specific and culturally appropriate interventions, increased investment, capacity-building, and awareness. The methodology involves gathering and analysing available data and literature to assess the current state of mental health provisions, policies, and gaps in Rajasthan, with a particular focus on women's mental health. It calls for comprehensive reforms to bridge the gap between policy intentions and implementation, enhance accessibility and availability of mental health services, and prioritize women's mental health. By adopting a gender-specific approach, Rajasthan can work towards achieving equitable and quality mental health care for all.

Keywords: World Health Organization, District Mental Health Programme, Mental health, Women, National Mental Health Programme.

INTRODUCTION

The preamble to WHO's constitution provides a definition of health- Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. "Indian culture from time immemorial recognises the relationship between mind, body & soul and its impact on mental health." says Dr. Harsh Vardhan, Former Minister of Health and Family Welfare, GOI. Despite all the awareness India still has a long journey ahead to truly achieve a mentally healthy society.

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Mental health encompasses a range of conditions, such as depression, schizophrenia, OCD, anxiety disorders, bipolar disorder, PTSD, psychosis, eating disorders, disruptive behaviour disorders, and neurodevelopmental disorders like intellectual development disorders, autism spectrum disorder, and ADHD. Mental health conditions are increasing worldwide. Mainly because of demographic changes, there has been a 13% rise in mental health conditions (World Health Organisation). It is estimated that more than 75% of people suffering from mental disorders in the world do not receive treatment (World Health Organisation).

Speaking or discussing about mental health is still a taboo, not just in India but across the globe; let alone acknowledging it. In the context of mental health concerns in development practice, the present paper attempts to analyse how women's health, especially mental health have been focussed on a specific regional context. It critically reviews some Policy Interventions for Women in the State of Rajasthan, to infer the depth of the issue and gender- based justice.

The paper is divided into three sections, with Section I providing a broad overview of mental health, Section II analysing the programs implemented by the Government of India and the Government of Rajasthan, and the concluding section synthesizing the main issues and insights derived from the analysis. By focusing on these interventions, this study aims to shed light on the current state of women's mental health and the efforts made by the government to address this critical issue in the State of Rajasthan.

SECTION I

Mental Health: An Overview (World Health Organization)

The World Health Organization is an agency of the United Nations responsible for International Public Health. It was established in 1948 and in the same year the first International Congress on Mental Health took place in London. At the second session of the WHO's Expert Committee on Mental Health (September 11-16, 1950), "mental health" and "mental hygiene" were defined (Bertolote, 2008). But, after decades of debates and conferences, World Health Organization defines mental health today as *"a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community."*

Mental health is more than absence of mental ailment. It is a basic Human Right. It is essential to understand that like any other health disorder mental health can be treated if diagnosed in time.

In recent years there has been increasing awareness for mental health as visible in the inclusion of mental health in the Sustainable Development Goals (Target 3.4 - Reduce premature deaths from noncommunicable diseases by one-third through prevention and treatment and promote mental health and well-being by 2030).

World Health Organization has taken various steps to curb the evil. Major recent initiatives include:

- Mental Health Action Plan (2013-30)
- Mental Health Gap Action Programme (mhGAP)
- Problem Management Plus manual
- Group Interpersonal Therapy for Depression manual
- Thinking Healthy manual

In May 2013, WHO's **Mental Health Action Plan 2013-2020** was adopted at the 66th World Health Assembly which was extended until 2030 by the 72nd World Health Assembly in May 2019 with refinement of a couple of targets, ensuring its continuity with the 2030 Agenda for Sustainable Development (Singh, 2021). The vision of the plan is ambitious: to make a world where mental health is promoted and valued; mental health treatments and facilities are culturally flexible to extend human rights to all. There should be highest level of health and society be free from discrimination, harassment, stigma and shame. (Saxena, Funk, & Chisholm, 2014). The original four major objectives remain unchanged: (Comprehensive Mental Health Action Plan 2013-2030, 2021)- a. More effective leadership and governance for mental health; b. The provision of comprehensive, integrated mental health and social care services in community-based settings; c. Implementation of strategies for promotion and prevention; d. Strengthened information systems, evidence and research.

Mental Health Gap Action Programme (mhGAP) aims at scaling up services for mental, neurological and substance use disorders in countries, especially those in the low- and middle-income categories. Since it was introduced in 2008, mhGAP has been introduced in over 100 countries, so that many people have been treated for depression, schizophrenia, and epilepsy, prevented from suicide and supported to lead normal lives – even where resources are scarce. Mental Health Atlas 2020

aims to provide up-to-date information on the existence of mental health services and resources around the world, including mental health policies, legislation and financing, the availability and utilization of mental health services, human resources and information/data collection systems (Kestel, 2021).

While some initiatives are necessary for global mental health improvement, they may be perceived as symbolic rather than substantive. This raises concerns about the level of commitment to inclusive mental health among international, national institutions, authorities, and the public. Notably, India is not a member country of the Mental Health Atlas 2020, resulting in a lack of data on its policies and response to mental health. Weak monitoring and limited efforts to establish strategic alliances with civil society/NGOs hinder policy implementation. The WHO emphasizes the vision, objectives, and goals for achieving universal mental health, including cultural appropriateness. However, solutions provided are often generic, failing to address why goals are unmet and neglecting the need for culture-specific measures. These gaps persist in policymakers' considerations.

SECTION II

Government Policy and Perspectives for Mental Health in India: A Select Study of Rajasthan

Implementation of the Programmes

"India was one of the first countries in the developing world to formulate a national mental health programme" (Welfare, 2022) (Prakash, 2018) (Khurana & Sharma, 2016). As early as 1982, the highest policy making body in the field of health in the country, the Central Council of Health and Family Welfare (CCHFW) adopted and recommended for implementation, a National Mental Health Programme for India (NMHP). The objectives of the programme were to cinch the attainability of mental healthcare, especially to the most vulnerable and underprivileged; to create general awareness regarding mental health; to encourage civic participation in the improvement of mental well-being and to foster self-help attitude in the society.

The District Mental Health Program (DMHP) was launched under NMHP in the year 1996 (in IX Five Year Plan) in four districts (Prakash, 2018). Now, it has developed to include 241 districts under the XII 5-year plan (2012-2017). The DMHP

was based on 'Bellary Model' (Prakash, 2018). It urges to enhance mental health care through early detection, physician training, public awareness campaigns, and monitoring for record keeping.

In 2016, a report was published by National Mental Health Programme in 2016 which had the following observation about India in general. It also gave state wise report.

Observation of the National Health Mental Programme (2016)

To strengthen mental health delivery there is a need to Strengthen system approach, Establish state mental health policies and programs, Integrate mental health with other health and welfare programs, Explore alternative resources, Enhance capacity building and human resource development, Increase engagement of health professionals and workers, Streamline mental health financing, Promote mental health activities and awareness, Improve coordination between agencies, Implement program monitoring and evaluation.

"In the last 40 years, the Government is supporting implementation of the District Mental Health Programme (DMHP) under NMHP in 704 districts of the country, under which, enhanced financial assistance of up to Rs. 83.20 lakhs per district per year is provided for detection, management and treatment of mental disorders/ illness and additional components." (Welfare, 2022).

The State of Rajasthan is one of the twenty- eight states in India where the status of women is particularly low, and discrimination is very high. Women in Rajasthan are least educated among other States as well as Union territories. Rajasthan has a patriarchal society where men enjoy superiority in all spheres of society. The patriarchy run so deep that most of the times facilities available to men is at the cost of women's basic rights. The Government of Rajasthan has initiated several programmes for women's development and empowerment in the State since 1980s (Rajagopal, 2004).

Despite being a health concern, mental health has not received much priority in a nation like India. India was one of the early Low- and middle-income countries (LMIC) to start a National Mental Health Programme (NMHP) way back in 1982 (Prakash, 2018) (Kaur, et al., 2023).

The National Mental Health Survey was taken forward by the National Institute of Mental Health and Neurosciences (NIMHANS) to fulfil these objectives across 12 selected states of India during 2015 – 16. The Report of Rajasthan are as follows-

Table 1: Coverage of District Mental Health Programme (DMHP)

1.	Districts with DMHP implemented in 12th plan period*(n)	6
2.	Districts with DMHP implemented prior to 12th plan (n)	1
3.	Districts covered by DMHP# (%)	21.21
4.	Population covered by DMHP (%)	25.23
5.	Tribal population covered by DMHP (%)	13.96

(*) Between 2012 and January 2016; #-Newly sanctioned DMHP districts in 2016 are not included; n-number

The data in Table 1 indicates both progress and areas for further improvement in the implementation of the District Mental Health Programme, including expanding coverage to more districts, increasing population coverage, and focusing on the mental health needs of tribal communities.

Data is also indicative of the fact that no special attention was given to a more vulnerable section i.e., women.

Table 2: Mental Health Care Facilities (MHCF)

	Availability of MHCF	Number	Availability per 1,00,000 population
1.	Mental Hospitals	2	<0.01
2.	Medical colleges with psychiatry department	5	<0.01
3.	General hospitals with psychiatry units	—	—
4.	% of district hospitals in the state providing outpatient/ in patient mental health services	—	—
5.	% of taluka hospitals in the state providing outpatient/ in patient mental health services	—	—
6.	% of Primary Health Centres in the state providing outpatient/ in patient mental health services	—	—
7.	Beds available for mental health inpatient services	512	0.75
8.	De-addiction units / Centres	6	<0.01
9.	Vocational training centres	1	<0.01
10.	Others (Residential half way homes, long stay homes, Hostel, Sheltered workshops, Mobile mental health units, Day care Centres)	—	—

Information Pertains to both Public and Private Health Care Facilities

In Table 2, the data indicates a significant lack of mental health care facilities, specifically with regard to women's mental health. The low availability of mental hospitals, medical colleges with psychiatry departments, de-addiction units, and vocational training centres highlights the need for increased investment and resources to address women's mental health concerns effectively. The absence of data for general hospitals, district hospitals, taluka hospitals, primary health centres, and other mental health care facilities further emphasizes the gaps in the availability of mental health services, making it difficult to assess the specific situation for women.

Table 3: Human Resources for Mental Health

	Types of HRMH	Number	Availability per 1,00,000 population
1.	Psychiatrists	68	0.10
2.	Clinical psychologists	9	0.01
3.	Nurses with DPN in qualification	6	0.01
4.	Psychiatric social workers	6	0.01
5.	Professional and paraprofessional psychosocial counsellors, Rehabilitation workers and Special education teachers	–	–

DPN- Diploma in Psychiatric Nursing

The Table number 3 indicates a limited availability of mental health professionals per 1,00,000 population. The number of psychiatrists, clinical psychologists, nurses with DPN qualification, and psychiatric social workers is relatively low. However, data for other mental health professionals, such as psychosocial counsellors, rehabilitation workers, and special education teachers, is not provided, making it challenging to assess the complete picture of human resources for mental health.

Table 4: Human Resource Trained in Mental Health

	Health personnel trained in mental health in the last 3 years	Number Trained	Percentage
1.	Doctors – MBBS	398	5.05
2.	Nurses	6	<0.01
3.	ANMs/Health Worker	2167	1.74
4.	ASHA/USHAs	2594	5.48%
5.	Doctors- Specialists, AYUSH doctors, Pharmacists	–	–

Information Pertains to Public Health Sector only

It is important to note that the information provided in the table is specific to the public health sector only. The data suggests that there has been some level of training in mental health for different categories of health personnel. However, the percentage of trained personnel remains relatively low for nurses and ANMs/Health Workers compared to the total number in each category. The absence of data for Doctors-Specialists, AYUSH doctors, and Pharmacists makes it difficult to assess the training status for these specific groups. Overall, while some efforts have been made to train health personnel in mental health, further investments and initiatives may be required to enhance the capacity of health professionals in addressing mental health issues effectively.

Table 5: Mental Health Financing

1.	Percentage of total health budget allotted for mental health by the state health department	–
2.	Percentage of mental health budget utilized	–

In Table 5, the absence of data regarding mental health financing in Rajasthan, specifically the percentage of the total health budget allotted for mental health and the percentage of the mental health budget utilized, can indicate a few possible scenarios such as, lack of prioritization, insufficient tracking or reporting mechanisms, limited transparency and accountability, potential underinvestment in mental health in Rajasthan.

Table 6: Burden and Treatment Gap of Mental Health Disorders

1.	Mental Health Disorders	Prevalence	Treatment Gap
2.	Common mental disorders	10.1%	87.4%
3.	Severe mental disorders	0.8%	71.4%
4.	Alcohol use disorder	2.6%	85.7%
5.	Depressive disorder	2.7%	93.9%
6.	High suicidal risk	1.0%	–

Source- National Mental Health Survey

The data in Table 6. suggests that there is a significant burden of mental health disorders in Rajasthan, and there is a substantial treatment gap in accessing mental health services. This emphasizes the importance of increasing awareness, improving accessibility to mental health services, and allocating sufficient resources to address the treatment gap and provide appropriate care for individuals with mental health disorders in Rajasthan.

The above results of the survey from the state of Rajasthan show extremely poor result and critical gap between mental health related provisions in National documents and its implementation at District and State level. The provided data (Table 1 to Table 6) suggests that while efforts have been made to implement mental health programs and establish care facilities in Rajasthan, there are still significant gaps in coverage, availability of services, human resources, and treatment provision for women's mental health.

CONCLUSION

The analysis reveals a significant gap in addressing women's mental health issues in Rajasthan at various levels: global, national, and state. Existing initiatives lack emphasis on gender-sensitive mental health solutions. Culturally appropriate treatment is essential due to the diverse factors influencing mental health across genders, regions, classes, nationalities, and ages. Gender sensitivity is not integrated into programs like the National Mental Health Programme and the District Mental Health Programme. The mental health needs of women and girls require specific attention and isolation within these programs. Currently, there are no provisions or schemes specifically addressing women's mental health at the national or state

level. This is concerning considering the existing stigma, taboo, and discrimination surrounding mental health, which disproportionately affect women. The survey data from Rajasthan highlights gaps in mental health provisions and services, particularly for women, indicating a need for increased investment and resources. The availability of mental health care facilities and professionals is alarmingly low. Insufficient data on mental health financing suggests inadequate investment. High burden of mental health disorders and treatment gaps underscore the need for awareness, accessibility, and resource allocation for women's mental health. To address these challenges, prioritizing mental health in policy and budget decisions, strengthening leadership and governance, integrating services with other health programs, investing in human resources training, and promoting awareness and de-stigmatization efforts are crucial. Partnerships with civil society organizations and the private sector can help fill gaps and improve mental health outcomes. Transformative approaches should challenge prevailing gender ideologies, develop a comprehensive understanding of women's mental health needs, ensure access to quality treatment, and create a supportive environment. Overall, comprehensive reforms are needed to provide equitable and quality mental health care for all, including women, in Rajasthan.

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This is to certify that **Ms VASUDHA PANDEY**, from University of Kota has presented a research paper entitled “Empowerment Reexamined: A Qualitative Study of Six Empowered Women Navigating Policy and Patriarchy in Rajasthan at the **International Conference on Gender, Law, and Society: Interaction and Innovation 2025**, (Online mode) organized jointly by the Department of Liberal Arts & Social Sciences and the Department of Law, held on 13–14 November 2025 at Manipal University Jaipur.

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3

GOOD HEALTH AND WELL-BEING

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National Conference

On

VIKSIT BHARAT @2047 STEPS TOWARDS PROSPERITY

विकसित भारत @ 2047 समृद्धि की ओर बढ़ते कदम

(19th - 20th JULY 2024)



CERTIFICATE

This is to certify that Prof./Dr./Mr./Ms. Vasudha Pandey, Research Scholar

University of Kota, Kota has chaired the session /participated/presented
a paper entitled Women's Participation in Viksit Bharat @2047: Focusing on Education in
of Differently - abled Women in Rajasthan

National Conference on "VIKSIT BHARAT" @2047 STEPS TOWARDS PROSPERITY organized

by Vardhman Mahaveer Open University, Kota and Khandelwal Vaish Girls Institute of Technology, Jaipur.

K. Bamele

Dr. Kshamta Chaudhary

Director
School of Humanities and Social Sciences
VMOU, Kota

An

Prof. Anju Gupta

Principal
KVGIT, Jaipur

Directorate of Research and Internal Quality Assurance Cell



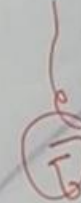
University of Kota

CERTIFICATE OF PARTICIPATION

This is to certify that Prof./Dr./Ms. Vagudha Pandey
from Department of P. Administration has actively Participated/Delivered a Talk
in the NATIONAL WORKSHOP on "Empowering Women for Leadership Skills"
organized by Directorate of Research, University of Kota during 24-25th July 2025.


Dr. Vipul Sharma
Organizing Secretary


Dr. Shweta Vyas
Co-convenor


Dr. N.L. Heda
Co-convenor


Prof. Reena Dadhich
Convener



International Conference

On

National Education Policy in India

(Transforming Education for a Sustainable Future)

5th - 6th September, 2023

Organized by: **BSN COLLEGE** | **SWAMI VIVEKANAND MAHILA**
Bakshawala, Sanganeer, Jaipur (Raj.) | **MAHAVIDHYALAYA**, Roopangarh, Ajmer

in collaboration with: **Savitribai Phule Organisation for Academic Research & Social Development, Jaipur**

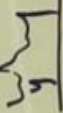


CERTIFICATE

This is to certify that Prof./Dr./Mr./Ms. VASUDHA PANDEY, RESEARCH SCHOLAR from GOVERNMENT ARTS COLLEGE, KOTA has participated in the international conference on 5th - 6th September, 2023 as Chair / Co-Chair / Keynote Speaker / Paper Author / Co-Author / Delegate and has presented a Paper on topic EMPOWERING WOMEN THROUGH SKILL DEVELOPMENT INITIATIVES IN ACCORDANCE WITH NEP-2020.

His/Her Participation is highly appreciated.


Patron
Dr. B.L. Devanda
Secretary, S.V.M.M.
Roopangarh, Ajmer


Coordinator
Dr. Prem Sonwal
Assistant Professor, SCRS Govt. College
Swai Madhopur


Convener
Chhavi Saini
Director, Savitribai Phule Organisation for Academic Research & Social Development, Jaipur


Organizing Secretary
Dr. Saroj Jangir
Principal, BSN College
Sanganeer, Jaipur



SOCIAL SCIENCES RESEARCH CENTRE
UNIVERSITY OF RAJASTHAN, JAIPUR

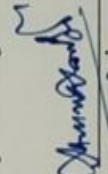
ONE WEEK NATIONAL WORKSHOP

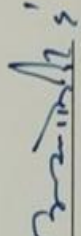
08th - 14th March, 2022

Certificate

This certificate is presented to Mr./Ms./Dr. Vasudha.Pandey, Research Scholar,...
Pub. Adm., Kota University, Kota... for successful participation in
One Week National Workshop on "Social Science Research Methodology" organized by
Social Science Research Centre, University of Rajasthan, Jaipur.


Dr. Amit Kumar Yadav
Course Co-Coordinator


Dr. Karunakar Singh
Course Coordinator/Dy. Director


Dr. Ashok Singh
Convener/Director