Project on "Gender and Mental Health in Assam: A Study on Magnitude, Cause and Impact of Mental Illness on Women"

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INTRODUCTION

Mental Health and Mental Illness: A layman's cogitation on mental health would reflect upon the same as the absence of psychopathologies, such as depression and anxiety. However, mental health connotes the general state of mind that conduces rational thinking, effective communication, learning, emotional development, resilience and a sense of self-worth. To gain a comprehensive insight into what mental health is, one may recall the WHO's definition of health: "A state of complete physical, mental and social well-being, and not merely the absence of disease" which refers to myriad activities directly or indirectly related to mental well-being of an individual. Mental health may broadly be defined as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make contribution to his or her community (WHO, 1948). In this respect, the predominant conception of Mental Health as negative is dispelled. In psychiatric locution, as Sadock informs us, the definition of normal (mental health) changes over time and is conditioned by the changing cultural norms, values and expectations typical of a particular society, professional biases, individual differences, and the political climate of the time. All human behaviour is located at some point or the other in the continuum of mental health and mental illness.

An attempt to depict the concept figuratively may be thus made:

Mental Health Mental Illness

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Healthy>>>>Adjustment Reaction>>>>Neurosis>>>>Psychosis

(Source: www.stockton.edu/~falkd/mhapproaches.ppt)

Mental illness refers to disorders generally characterized by dys-regulation of mood, thought, and/or behaviour, as recognized by the Diagnostic and Statistical Manual, 4th edition, of the American Psychiatric Association (DSM-IV). In the parlance of medical science, mental illnesses is a medical condition that dishevels a person's thinking, feeling, mood, ability to relate to others and daily functioning thereby diminishing an individual's capacity for coping with the everyday mundane demands of life. Deviance and mental illness share a hand and glove relation.

Though not all deviants are classified as mentally ill, conventionally there has been a tendency to brand/label almost all mentally ill persons as deviants. This stems from the preconception that mental illness is not normal. Therefore, in the studies on deviance focus has often been directed to mental illnesses as well.

Mental health problems are among the most important contributors to the global burden of disease and disability. Mental and behavioural disorders are estimated to account for 12% of disability-adjusted life-years lost globally and 31% of all years lived with disability at all ages and in both sexes, according to the year 2000 estimates. Yet, more than 40% of countries have no mental health policy, over 90% have no mental health policy that includes adolescents and children, and over 30% have no mental health programmes (World Health Organization, The World Health Report 2001. Mental Health: New Understanding, New Hope. Geneva: World Health Organization: 2001).

Gender and Mental Health: Gender is a term that refers to the socially constructed understanding of what the male and the female characterize. It stands in opposition to the concept of sex which connotes biologically determined characteristics. Gender influences the differential power men and women exercise in controlling their lives, cope with such risks and influence the process of health development (Pan American Health Organization, 1995). As such, gender is important in defining susceptibility and exposure to a number of mental health risks. If it is accepted that both women and men have a fundamental right to mental health, it becomes impossible to examine the impact of gender on mental health without considering gender-based discrimination and gender-based violence. This means that gender issues are not just of concern to women but gender divisions also affects men in both positive and negative ways. Environmental factors, such as social support, economic status, and cultural expectations, differ by gender and may impact on an individual's vulnerability to mental illness. Studies suggest that, in the context of mental illness, women are more affected by marital discord than men, and that men are more likely to be affected by work-related stress. These trends may have as much to do with gender roles and experiences as with biological sex. Gender affects the differences in patterns of help seeking and gender stereotyping in diagnosis compound difficulties with identification and treatment. A gender approach to mental health enables the

identification of appropriate responses from the mental healthcare system, as well as from public policy. Gender differences in mental disorders extend beyond differences in the rates of various disorders or their differential time of onset or course and include a number of factors that can affect risk or susceptibility, diagnosis, treatment and adjustment to mental disorder. Therefore, exploration of mental illness, with respect to gender difference is an important domain for exploration. However, within the limited scope of the study an attempt has been made to study mental illness with particular focus on women.

Women and Mental Health: It is not until the 1980s, when feminist critiques of science began to appear, that gender began to be taken on board in scientific researches. Prior to that, theories on mental health reflected blatant gender blindness by harping upon women's biologically based vulnerability to mental disorder. In the case of disorders like depression, this confounding of sex and gender impelled many researchers to a search for biological causes of depression that by preordained prejudice could only be found to exist in women.

Notions of women's biologically based vulnerability disorder have sustained over time and are embedded in the long history of hysteria and the attendant belief that women have an innate tendency to mental disorder. As a result, mental disorder was believed to relate to a corresponding derangement or malfunctioning of women's reproductive organs and hormones. The hypothesised relationship between reproductive related events such as menstruation, pregnancy, miscarriage, childbirth, premature delivery, infertility, abortion and menopause and women's higher rates of depression has of late courted much attention. This individualizing focus on reproductive factors has for a long time diverted research focus from social and structural determinants of women's mental health. The importance and attention paid by researchers to reproductive functioning are not, necessarily, in sync with women's own perspectives and health priorities, but these have influenced research agenda for long. Thus, research on gender and mental illness abounded in assumptions, myths and culturally biased attitudes towards women. Therefore, the need to adopt an integrationist model, which studies the biological causes of women's mental illness in conjugation with other social, economic and psychological factors, is compelling.

Women overall wellbeing in a society is determined to a great extent in terms of socio-economic indicators such as income, poverty, education and skills that opens up opportunities of employment, better health etc. These indices are also vitally interlinked with the concepts of power and position. At the same time, women's autonomy in the decision making process in the family and in the public sphere, and access to rights and opportunities provided by the state and society at large impact upon their status and may have a bearing upon their mental health. It is therefore imperative that, to explore the cause and impact of mental illness of women, one needs to take cognizance of the social, economic and institutional factors prevalent in a society. For, these factors have an impact on women's status; dignity and autonomy which are vitally linked to their mental well-being. Women are socialized in such a manner that they seek recognition from the male gaze. The male gaze 'shapes' the women's body and makes her conscious of her identity and continuously learn and adopt feminine roles which can be appreciated by the system of patriarchy in society. If sometimes someone fails to fulfil the demand of male gaze they may feel inferior and insecure leading to depression and a loss of self-esteem. Hence, mental health problems in women often started because of the failure to fulfil the demands of the patriarchal society. North East India is the most neglected area in terms of health sector. As per the data from the National Survey of Mental Health Resources conducted by the Directorate General of Health Services, Ministry of Health and Family welfare, Govt. of India in 2002, which was published as an Annual Report (2008-2009) of LGBRIMH, Tezpur, the total population of North East region was approximately 40 million and out of these about 3,85,000 people were estimated to suffer from major mental illness while about 19,25,000 were estimated to have minor mental disorder. Arup Jyoty Saikia in his article 'Literary History, Orality and Discourses of Madness: A Note on the Social History of Assam' mentioned that the documents of mental hospital powerfully indicate the trajectory of the construction of madness since the mid-19th century. This study examines the interaction between mental illness, socio-economic influences and institutional responses towards the same with special focus directed at women of Assam. Assam represents a multi-cultural context, where several ethnic communities co-exist. Each of the communities is set apart from the other in terms of the indigenous socio-cultural norms as also in terms of their economic status. The aim of the study is to relate mental illness among women to social, economic determinants and also to explore the institutional response towards mental illness, with regard to the women.

OBJECTIVES OF THE STUDY

1. Estimate the number of women and girls afflicted by mental illness in Assam. Generate gender differentiated data with regard to prevalence of mental illness in Assam.
2. Study the socio-cultural factors affecting mental health and impact of mental illness among women on society.
3. Study the economic factors affecting mental health and impact of mental illness among women on economy.
4. Study physical health factors in relation to mental health.
5. Study social response to mental illness.
6. Study institutional response to mental illness.

METHODOLOGY

A. Data Collection

The study relied on both primary and secondary sources for data generation.

The secondary data was generated from:

- Books
- Journals
- Reports compiled/written by NGOs/Institutions of Mental Health/Research organizations etc. on Assam and other parts of the world.

The primary data was generated by the following means:

- Household Survey
- Hospital Survey
- Interview with key informants (health practitioners, traditional healers, community representatives)
- Focus Group discussions at community level (SHGs, panchayat office, temples/mosques/churches)

For collection of primary data, a multi-stage sampling technique was employed.

- For the purpose of this study 10 out of 27 districts of Assam (*viz*. *Sonitpur*, *Darrang*, *Dibrugarh*, *Jorhat*, *Golaghat*, *Bongaigaon*, *Tinsukia*, *Cachar*, *Sibsagar*, *Kamrup*) were selected for the purpose of the study.
- Out of the 219 CD blocks in 27 districts, 20 blocks (two blocks from each district) were randomly selected. This cannot be accepted as indicator of severity.
- Out of the 20 blocks, 5 villages from each of the block were randomly selected for the study. Thus, the sample respondents were selected from 100 villages.
- Once the villages were identified, 7-10 households were identified from each village for the sample. The selection of households was purposive, as the identification of households with female patients was imperative.
- Thus, a total number of 1000 households were purported for the survey.

B. Data Analysis

For the purpose of Data Analysis, both qualitative and quantitative methods were adopted.

- Qualitative analysis was adopted to analyse the data generated from FGDs and Key Informants.
- Quantitative analysis was done employing the SPSS (ver. 20), to analyse relationship between different variables of study. Simple statistical tools like frequency, mean, cross-tabulation and chi square test were used for analysis as well.
- However, the data generated from *Sivasagar district and from two (2) other villages of Dibrugarh could not be quantitatively analysed for discrepancies in data collected.
- ***Therefore the quantitative analysis was conducted on samples from nine (9) districts, eighteen blocks (18), 88 villages and 830 households.***
- ***The sample, hence, constitutes of 830 Households*** (having mentally ill patients as well as those not having mentally ill patients).

*The field assistant had met with an accident during a field visit, which subsequently affected his work as recuperation took time. The data eventually collected was inadequate and therefore, could not be taken into account in quantitative analysis. However, the same has been considered in qualitative analysis. In the case of Dibrugarh, data from two villages had discrepancies, hence could not be used.

Table 1: SAMPLE PROFILE CHART - Name of Block / Name of Village / Name of District Cross-tabulation

NAME OF DISTRICT												TOTAL
Tinsukia	Name of Block	Itakhooli					Hapjan					2
	Name of Village	Mahakali T.E	Borjaan (Pagola Basti)	Monkhadi Gaon	Bahadurbagan	Dewhaal	Anandabag T. E	Hahsara	Begenabari	Dighal Tarang T.E	Lesengka Bongali Gaon	10
	Respondents	10	9	11	10	10	10	10	11	7	9	97
Darrang	Name of Block	Pub-Mangaldoi					Pachim-Mangaldoi					2
	Name of Village	Balabari	Bandia	Chaulkhuwa	Dhula	Abhaypukhuri	Ramhari	Nagarbahi	Chapai	Dahi	Upahupara	10
	Respondents	10	10	8	10	9	9	10	10	10	10	96
Bongaigaon	Name of Block	Dangtol					Srijangram					2
	Name of Village	Chokapara	Ghandal	Mazgaon	Siponchila	Jakuapara	Pakhiriguri	Mojaimukh	Lengtisingapara	Gunialguri	Narikola	10
	Respondents	10	10	10	10	10	10	10	10	10	10	100
Golaghat	Name of Block	Morongi					Sarupathar					2
	Name of Village	Panikora	2 No. Koibatra	Sesamukh	TeliaGaon	Patkotia	1 No. Tengakhola	Moran Gaon	2 No. Tengakhola	Gondhkoroiguri 2	Latajuri	10
	Respondents	10	10	10	10	10	10	10	10	10	10	100
Sonitpur	Name of Block	Sootea					Biswanath					2
	Name of Village	Ghahigaon	Pathekakuri	Habidoloni	Bhuyanpara	Hokajan	Panibharal	Balipukhuri	Gorehagi	Bhirgaon	Maral Gaon	10
	Respondents	10	10	10	10	10	9	9	9	9	8	94
Kamrup	Name of Block	Hajo					Boko					2
	Name of Village	Manahkuchi	Hadala	Gerua	Kalitakuchi	Bardadhi	Dakuawapara	Behuwa	Dilinga	Hahim	Pakhrapara	10
	Respondents	9	9	9	9	9	9	10	9	9	10	92
Dibrugarh	Name of Block	Borboruah					Khowang					2
	Name of Village	Lezai	Bokpara	Tekela Siring	Jamira Kopou Gaon		Khowang Kawoimari Gaon	Dulonikur	Kumargaon	Bukakhola		8
	Respondents	11	10	10	10		9	10	10	9		79
Cachar	Name of Block	Silchar					Borjalenga					2
	Name of Village	Saidarpur IV	Chandrapur I	Daspara	Ambikapur 10	Chottojalenga	Duarbond	Rosekandi	Silcoorie	Loharbond	Bariknagar	10
	Respondents	7	7	10	8	9	10	3	8	4	9	75
Jorhat	Name of Block	Sipahikhula					Baghchung					2
	Name of Village	Diha Gajpuri	Kamar Khatowal	Bam Kukurasuwa	Dewan Gaon	Korchoguri Gohain Gaon	Cinnamara Sadar	Cinnamara T.E 2 no. Line	Cinnamara Bar Bangla	Na Ali Kamalabari	Cinnamara Buddha Mandir	10
	Respondents	10	10	8	9	10	10	10	10	10	10	97

TABLE SUMMARY	
District/Block/Village	TOTAL
Number of Districts	9
Number of Blocks	18
Number of Villages	88
Number of Respondents	830

C. Universe of Study

For the study the data was generated from ten (10) randomly selected districts of Assam. The Population of Assam according to the 2011 census stands at about 31 million (which male and female are 15,939,443 and 15,266,133 respectively), making it the 14th most populated state in India. The state constitutes about 2.5% of the country's population, a figure that has gone up since the last census in 2001. The state is spread over an area of about 78,000 sq. km. making it the 16th largest state in the country in terms of area. Assam has 27 districts, which are further divided into 49 sub-divisions and 219 blocks.

The study was conducted on 10 districts of Assam. The districts selected for the study include:

Table 2: Selected Districts and Codes Assigned

Sl. No. 1	Bongaigaon	Dist. Code: 1
2	Cachar	Dist. Code: 2
3	Darrang	Dist. Code: 3
4	Dibrugarh	Dist. Code: 4
5	Golaghat	Dist. Code: 5
6	Jorhat	Dist. Code: 6
7	Kamrup	Dist. Code: 7
8	Sivasagar	Dist. Code: 8
9	Sonitpur	Dist. Code: 9
10	Tinsukia	Dist. Code: 10

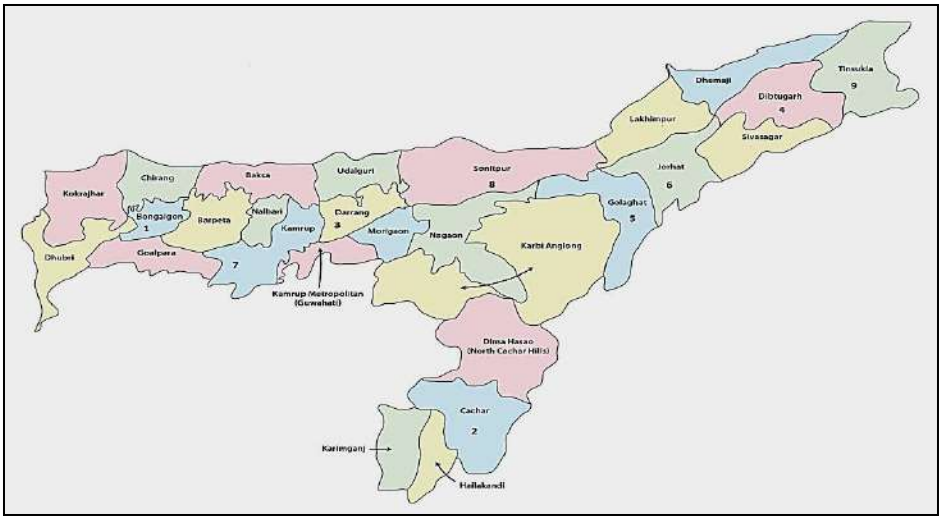


Fig 1: Selected Districts of the Study

Table 3: Details of Districts Selected

Sl. No.	District	Headquarters		Population (Census 2011)	Sex Ratio (per 1000)	Average Literacy
1	Bongaigaon	Bongaigaon		738,804	966	69.74%
2	Cachar	Silchar		1,736,617	959	79.34%
3	Darrang	Mangaldoi		928,500	954	63.08%
4	Dibrugarh	Dibrugarh		1,326,335	961	76.05%
5	Golaghat	Golaghat		1,066,888	964	77.43%
6	Jorhat	Jorhat		1,092,256	962	82.15%
7	Kamrup	Goroimari		1,517,542	949	75.55%
8	Sivasagar	Sibsagar		1,151,050	954	80.41%
9	Sonitpur	Tezpur		1,924,110	956	67.34%
10	Tinsukia	Tinsukia		1,327,929	952	69.66%

Out of the ten (10) districts and 20 blocks identified the following villages were randomly selected from which a total of 88 villages were studied, which yielded data from 830 households. Following, is a collated profile of the villages studied.

4 a. BONGAIGAON

Profile of Villages under Dangtol Block

Village	Sub-div.	Circle	Male Pop^{n} (2011 census)	Female Pop^{n} (2011 census)	Total Pop^{n} (2011 census)
Chokapara	Bongaigaon	Bongaigaon	567	563	1130
Majgaon	Bongaigaon	Bongaigaon	412	415	827
Ghandal	Ghandal	Bongaigaon	414	435	849
Siponchila	Bongaigaon	Bongaigaon	358	357	715
Jakuapara	Bongaigaon	Bongaigaon	480	444	924

Profile of Villages under Srijangram Block

Village	Sub-div.	Circle	Male Pop^{n} (2011 census)	Female Pop^{n} (2011 census)	Total Pop^{n} (2011 census)
Gunialguri	North-Salmara	Bongaigaon	313	319	632
Mojairmukh	North-Salmara	Bongaigaon	342	315	657
Pakhiriguri	North-Salmara	Srijangram	379	415	794
Lengtisinga para	North-Salmara	Srijangram	197	199	396
Narikola	North-Salmara	Bongaigaon	296	332	628

4 b. SONITPUR

Profile of Villages under Sootea Block

Village	**Sub-div.**	**Circle**	**Male Pop^{n}** (2011 census)	**Female Pop^{n}** (2011 census)	**Total Pop^{n}** (2011 census)
Pathekakuri	Tezpur	Na-duar	516	502	1018
Habidoloni	Tezpur	Na-duar	557	547	1104
Bhuyanpara	Tezpur	Na-duar	519	488	1007
Ghahigaon	Tezpur	Na-duar	1209	1148	2357
Hokajan	Tezpur	Na-duar	500	479	979

Profile of Villages under Biswanath Chariali Block

Village	Sub-div.	Circle	Male Pop[n] (2011 census)	Female Pop[n] (2011 census)	Total Pop[n] (2011 census)
Gore Hagi	Biswanath	Biswanath	813	803	1616
Pani Bhoral	Biswanath	Biswanath	701	707	1408
Bali Pukhuri	Biswanath	Biswanath	1220	1208	2428
BhirGaon	Biswanath	Biswanath	2191	2141	4332
MaralGaon	Biswanath	Biswanath	795	797	1592

4 c. KAMRUP

Profile of Villages under Boko Block

Village	Sub-div.	Circle	Male Pop[n] (2011 census)	Female Pop[n] (2011 census)	Total Pop[n] (2011 census)
Behua	Guwahati	Boko	428	425	853
Dilinga	Guwahati	Boko	621	619	1240
Hahim	Guwahati	Boko	431	458	886
Pakhrapara	Guwahati	Boko	619	624	1243
Dakuwapara	Guwahati	Boko	1525	1491	3016

Profile of Villages under Hajo Block

Village	Sub-div.	Circle	Male Pop[n] (2011 census)	Female Pop[n] (2011 census)	Total Pop[n] (2011 census)
Gerua	Guwahati	Hajo	567	493	1060
Monahkuchi	Guwahati	Hajo	3206	3084	6290
Kalitakuchi	Guwahati	Hajo	1878	1722	3650
Bardadhi	Guwahati	Hajo	1522	1472	2994
Hadala	Guwahati	Hajo	725	645	1370

4 d. DARRANG

Profile of Villages under Pub-Mangaldoi Block

Village	Sub-div.	Circle	Male Pop^{n} (2011 census)	Female Pop^{n} (2011 census)	Total Pop^{n} (2011 census)
Dhula	Mangaldoi	Mangaldoi	3006	2962	5968
Bandia	Mangaldoi	Mangaldoi	626	593	1219
AbhayPukhuri	Mangaldoi	Mangaldoi	297	302	599
Balabari	Mangaldoi	Mangaldoi	1179	1180	2359
Chaulkhuwa	Mangaldoi	Mangaldoi	1265	1182	2447

Profile of Villages under PachimMangaldoi Block

Village	Sub-div.	Circle	Male Pop^{n} (2011 census)	Female Pop^{n} (2011 census)	Total Pop^{n} (2011 census)
Dahi	Mangaldoi	Mangaldoi	987	930	1917
Upahupara	Mangaldoi	Mangaldoi	298	289	587
Chapai	Mangaldoi	Mangaldoi	428	396	824
Ramhari	Mangaldoi	Mangaldoi	587	298	885
Nagarbahi	Mangaldoi	Mangaldoi	868	848	1716

4 e. DIBRUGARH

Profile of Villages under Barbaruah Block

Village	Sub-div.	Circle	Male Pop^{n} (2011 census)	Female Pop^{n} (2011 census)	Total Pop^{n} (2011 census)
Bokpara	Dibrugarh	East-revenue	721	746	1467
Tekalasiring	Dibrugarh	West-revenue	836	678	1514
Lezai	Dibrugarh	West-revenue	836	678	1514
Jamira Kapou Gaon	Dibrugarh	West-revenue	567	563	1130

Profile of Villages under Khowang Block

Village	Sub-div.	Circle	Male Pop^{n} (2011 census)	Female Pop^{n} (2011 census)	Total Pop^{n} (2011 census)
Khowang KawoiMarigaon	Dibrugarh	Moran	666	503	1169
Bukakhola	Dibrugarh	Moran	240	260	500
Kumargaon	Dibrugarh	Moran	836	678	1514
Dolonikur	Dibrugarh	Moran	361	305	666

4 f. CACHAR

Profile of Villages under Silchar Block

Village	Sub-div.	Circle	Male Pop^{n} (2011 census)	Female Pop^{n} (2011 census)	Total Pop^{n} (2011 census)
Saidpur IV	Silchar	Silchar	1662	1685	3347
Chandrapur I	Silchar	Silchar	1946	1861	3807
Ambikapur X	Silchar	Silchar	7309	6974	14283
***Daspara**	Silchar	Silchar	-	-	-
Chottojalenga	Silchar	Silchar	138	126	264

***data not available from census report**

Profile of Villages under Borjalenga Block

Village	Sub-div.	Circle	Male Pop^{n} (2011 census)	Female Pop^{n} (2011 census)	Total Pop^{n} (2011 census)
Rosekandi	SilcharSadar	Silchar	1111	1130	2241
Silcoorie	SilcharSadar	Silchar	10087	9550	19637
Duarbond	SilcharSadar	Silchar	1650	1535	3185
Bariknagar	SilcharSadar	Silchar	591	618	1209
Loharbond	SilcharSadar	Silchar	79	75	151

4 g. JORHAT

Profile of Villages under Sipahikhula Block

Village	Sub-div.	Circle	Male Pop^{n} (2011 census)	Female Pop^{n} (2011 census)	Total Pop^{n} (2011 census)
Diha Gajpuria	Jorhat	Jorhat East	775	767	1542
Dewan Gaon	Jorhat	Jorhat East	764	549	1313
Bam Kukurasuwa	Jorhat	Jorhat East	836	678	1514
Korchoguri Gohai Gaon	Jorhat	Jorhat East	652	588	1240
Komarkhatowal	Jorhat	Jorhat East	973	817	1790

Profile of Villages under Baghchung Block

Village	Sub-div.	Circle	Male Pop^{n} (2011 census)	Female Pop^{n} (2011 census)	Total Pop^{n} (2011 census)
Cinnamara Bor Bangla	Jorhat	Jorhat East	768	569	1337
CinnamaraSadar	Jorhat	Jorhat East	834	726	1560
Cinnamara Buddha Mandir	Jorhat	Jorhat East	570	423	993
Na Ali Kamalabari Gaon	Jorhat	Jorhat East	965	867	1832
Cinnamara TE 2 no. Line	Jorhat	Jorhat East	666	503	1169

4 h. GOLAGHAT

Profile of Villages under Marangi Block

Village	Sub-div.	Circle	Male Pop^{n} (2011 census)	Female Pop^{n} (2011 census)	Total Pop^{n} (2011 census)
Telia Gaon	Golaghat	Doigrung	488	466	954
Panikora	Golaghat	Doigrung	542	524	1066
2 no. Kaibatra	Golaghat	Doigrung	466	437	903
Sesamukh	Golaghat	Doigrung	216	201	417
Patkotia	Golaghat	Doigrung	784	799	1583

Profile of Villages under Sarupathar Block

Village	Sub-div.	Circle	Male Pop[n] (2011 census)	Female Pop[n] (2011 census)	Total Pop[n] (2011 census)
1no. Tengakhola	Sarupathar	Sarupathar	488	466	954
Moran Gaon	Sarupathar	Sarupathar	741	727	1468
2 no. Tengakhola	Sarupathar	Sarupathar	420	411	831
2 no. Gondhokoroiguri	Sarupathar	Sarupathar	909	919	1828
Latajuri	Sarupathar	Sarupathar	454	445	899

4 i. TINSUKIA

Profile of Villages under Hapjan Block

Village	Sub-div.	Circle	Male Pop[n] (2011 census)	Female Pop[n] (2011 census)	Total Pop[n] (2011 census)
Lesengka Bongali Gaon	Tinsukia	Doomdooma	945	946	1,891
Bengenabari*	Tinsukia	Duoomdooma	-	-	-
Hahsara	Tinsukia	Duoomdooma	827	882	1709
Anandabag TE	Tinsukia	Duoomdooma	713	795	1,508
Dighaltarang T.E.	Tinsukia	Duoomdooma	711	720	1431

***data not available from census report**

Profile of Villages under Itakhooli Block

Village	Sub-div.	Circle	Male Pop[n] (2011 census)	Female Pop[n] (2011 census)	Total Pop[n] (2011 census)
Monkhadi	Tinsukia	Tinsukia	900	1059	1959
Dewhaal	Tinsukia	Tinsukia	233	244	477
Bahadur Bagaan	Tinsukia	Tinsukia	824	870	1694
Mahakali T.E.	Tinsukia	Tinsukia	2384	2408	4,792
Borjaan (Pagala Basti)	Tinsukia	Tinsukia	921	864	1785

DETAILED ANALYSIS

A. Magnitude of Mental Illness in Assam

From the information generated from secondary sources it is evident that the magnitude of mental illness is quite high though the same may not be on record owing to the social stigma associated with the same. The present study, within its scope, cannot provide an accurate estimation of the magnitude of mental illness. However, the data generated from selected hospitals may be indicative of the proportion of mental illness in Assam.

Table 5: Institutional Data

Sl.No.	Hospital / Institute/ NGO	Total No. of cases (OPD)	Male	Female
1.	LGB Regional Institute of Mental Health *(2010 – 2014)	4,10,982	22,5337	18,5645
2.	Jorhat Medical College *(2009- 2014)	14,943	9,556	5, 387
3	Assam Medical College *(2013-2014)	823 (gender differentiated data is not recorded)	-	-
4.	Tezpur Medical College and Hospital (estd. 2014)	526	272	254
5.	Mangaldoi Civil Hospital *(2014)	205	90	115

***Data retrieved as recorded in official documents**

Magnitude of Mental Illness among Women: The data is definitely indicative of the prevalence of mental illness in Assam. The ever increasing stress in our lives at the present times owing to the multifarious demands of both personal and professional domains coupled with social and economic factors influencing one's life imply the vulnerability towards mental illness has increased. However, it is important to note that according to the official records the number of male patients is more. This should not however be interpreted as prevalence of mental illness as more among men than women. Rather, the same may be suggestive of the fact that women avail institutional health care less frequently than men. The health (mental health for that matter) of women are accorded less importance and therefore, the institutional records, generally record fewer number of female patients.

The secondary data explored revealed that women were more prone to mental illness owing to their social and economic status in a male dominated society. The normative standard in which the life of women is bound makes them particularly susceptible to mental distress.

Following is a collation of the percentage of women (as against the total female population) afflicted with mental illness in the districts covered for study. The IPSS technique has been employed for the analysis. ***This technique interviewed ten key informants from each village to generate names of ten individuals afflicted with mental illness in their area. The names of the common individuals were then eliminated and the percentage of women suffering from mental illness was calculated.***

6 a. BONGAIGAON DISTRICT

Block	**Dangtol**				**Srijangram**			
Total Population	Male		Female		Male		Female	
	2231		2214		1527		1580	
Total no. of Probable Cases	Male		Female		Male		Female	
	88		48		78		52	
Total no. of Common Cases	Male		Female		Male		Female	
	65		25		59		34	
Avg. No. of Probable Symptoms	5				4			
Most Common Symptoms	2,8,10,11,14				8,9,14			
Prevalence Rate	Gender Specific (M:F)	Age Specific			Gender Specific (M:F)	Age Specific		
	1:1	Male	Female		20:19	Male	Female	
		20-60	20-60			20-60	20-60	
Percentage of Women Afflicted	1.084% of the total female population				1.202% of the total female population			
District's Total Percentage of Women Afflicted	1.133% of the total female population							

Table 6a

6 b. CACHAR DISTRICT

Block	**Silchar**				**Borjalenga**			
Total Population	Male		Female		Male		Female	
	11055 (approx.)		10646 (approx.)		13518		12908	
Total no. of Probable Cases	Male		Female		Male		Female	
	20		21		23		20	
Total no. of Common Cases	Male		Female		Male		Female	
	11		12		15		10	
Avg. No. of Probable Symptoms	5				5			
Most Common Symptoms	1,3,6,8				1,3,6			
Prevalence Rate	Gender Specific (M:F)	Age Specific			Gender Specific (M:F)	Age Specific		
	1:1	Male	Female		9:11	Male	Female	
		20-60	20-60			20-60	20-60	
Percentage of Women Afflicted	0.093% (approx.) of the total female population				0.085% of the total female population			
District's Total Percentage of Women Afflicted	0.089% (approx.) of the total female population							

Table 6b

6 c. DARRANG DISTRICT

Block	Pub- Mangaldoi				Pachim Mangaldoi			
Total Population	Male		Female		Male		Female	
	6373		6219		3168		2761	
Total no. of Probable Cases	Male		Female		Male		Female	
	25		25		26		24	
Total no. of Common Cases	Male		Female		Male		Female	
	17		13		10		1	
Avg. No. of Probable Symptoms	5				5			
Most Common Symptoms	3				3			
Prevalence Rate	Gender Specific (M:F)	Age Specific			Gender Specific (M:F)	Age Specific		
	9:13	Male	Female		17:24	Male	Female	
		20-60	20-60			20-60	20-60	
Percentage of Women Afflicted	0.209% of the total female population				0.869% of the total female population			
District's Total Percentage of Women Afflicted	0.412% of the total female population							

Table 6c

6 d. DIBRUGARH DISTRICT

Block	Barbaruah				Khowang			
Total Population	Male		Female		Male		Female	
	2960		2665		2103		1746	
Total no. of Probable Cases	Male		Female		Male		Female	
	9		20		5		20	
Total no. of Common Cases	Male		Female		Male		Female	
	1		1		1		1	
Avg. No. of Probable Symptoms	5				5			
Most Common Symptoms	2,9				3			
Prevalence Rate	Gender Specific (M:F)	Age Specific			Gender Specific (M:F)	Age Specific		
	9:20	Male	Female		1:4	Male	Female	
		20-60	20-60			20-60	20-60	
Percentage of Women Afflicted	0.750% of the total female population				1.145% of the total female population			
District's Total Percentage of Women Afflicted	0.907% of the total female population							

Table 6d

6 e. GOLAGHAT DISTRICT

Block	Marangi				Sarupathar			
Total Population	Male		Female		Male		Female	
	2496		2427		3012		2968	
Total no. of Probable Cases	Male		Female		Male		Female	
	64		97		75		96	
Total no. of Common Cases	Male		Female		Male		Female	
	13		24		17		27	
Avg. No. of Probable Symptoms	6				6			
Most Common Symptoms	2,4,8,9				2,4,9			
Prevalence Rate	Gender Specific (M:F)	Age Specific			Gender Specific (M:F)	Age Specific		
	21:37	Male	Female		59:70	Male	Female	
		20-60	20-60			20-60	20-60	
Percentage of Women Afflicted	3.049% of the total female population				2.358% of the total female population			
District's Total Percentage of Women Afflicted	2.669% of the total female population							

Table 6e

6 f. JORHAT DISTRICT

Block	Sipahikhula				Baghchung			
Total Population	Male		Female		Male		Female	
	4000		3399		3803		3088	
Total no. of Probable Cases	Male		Female		Male		Female	
	25		25		19		27	
Total no. of Common Cases	Male		Female		Male		Female	
	12		12		7		8	
Avg. No. of Probable Symptoms	5				5			
Most Common Symptoms	2				2			
Prevalence Rate	Gender Specific (M:F)	Age Specific			Gender Specific (M:F)	Age Specific		
	1:1	Male	Female		13:20	Male	Female	
		20-60	20-60			20-60	20-60	
Percentage of Women Afflicted	0.412% of the total female population				0.647% of the total female population			
District's Total Percentage of Women Afflicted	0.524% of the total female population							

Table 6f

6 g. KAMRUP DISTRICT

Block	Boko				Hajo			
Total Population	Male		Female		Male		Female	
	3624		3617		7898		7416	
Total no. of Probable Cases	Male		Female		Male		Female	
	35		40		28		42	
Total no. of Common Cases	Male		Female		Male		Female	
	3		5		4		7	
Avg. No. of Probable Symptoms	4				6			
Most Common Symptoms	2				2			
Prevalence Rate	Gender Specific (M:F)	Age Specific			Gender Specific (M:F)	Age Specific		
	11:12	Male	Female		25:36	Male	Female	
		20-60	20-60			20-60	20-60	
Percentage of Women Afflicted	0.995% of the total female population				0.485% of the total female population			
District's Total Percentage of Women Afflicted	0.652% of the total female population							

Table 6g

6 h. SONITPUR DISTRICT

Block	Sootea				BiswanathChariali			
Total Population	Male		Female		Male		Female	
	3301		3164		5720		5656	
Total no. of Probable Cases	Male		Female		Male		Female	
	38		49		28		41	
Total no. of Common Cases	Male		Female		Male		Female	
	9		15		13		20	
Avg. No. of Probable Symptoms	5				6			
Most Common Symptoms	2,4,14				2,9,14			
Prevalence Rate	Gender Specific (M:F)	Age Specific			Gender Specific (M:F)	Age Specific		
	6:7	Male	Female		8:11	Male	Female	
		20-60	20-60			20-60	20-60	
Percentage of Women Afflicted	1.106% of the total female population				0.389% of the total female population			
District's Total Percentage of Women Afflicted	0.64% of the total female population							

Table 6h

6 i. TINSUKIA DISTRICT

Block	Hapjan				Itakhooli			
Total Population	Male		Female		Male		Female	
	3196 (approx.)		3343 (approx.)		5262		5445	
Total no. of Probable Cases	Male		Female		Male		Female	
	6		25		5		23	
Total no. of Common Cases	Male		Female		Male		Female	
	3		2		1		2	
Avg. No. of Probable Symptoms	6				6			
Most Common Symptoms	6,5				6			
Prevalence Rate	Gender Specific (M:F)	Age Specific			Gender Specific (M:F)	Age Specific		
	1:6	Male	Female		5:22	Male	Female	
		20-60	20-60			20-60	20-60	
Percentage of Women Afflicted	0.718% (approx.) of the total female population				0.404% of the total female population			
District's Total Percentage of Women Afflicted	0.523% (approx.) of the total female population							

Table 6i

Therefore, the cumulative percentage of women afflicted with mental illness in the districts is analysed as below. However, the data is only indicative as the scale of study is limited (ten key informants have identified ten cases, out of which the common cases were ruled out for the calculation). ***In this context therefore, reference to the male-female cumulative ratio of 177:247 is clearly indicative of the prevalence of mental illness as much more among women than men*.**

Cumulative Data of Ten Districts of Assam				
Total Population	Male		Female	
	85237 (approx.)		81262 (approx.)	
Total no. of Probable Cases	Male		Female	
	597		695	
Total no. of Common Cases	Male		Female	
	244		202	
Avg. No. of Probable Symptoms	5			
Most Common Symptoms	2,3,6.8.9,14			
Prevalence Rate	Gender Specific (M:F)	Age Specific		
	177:247	Male	Female	
		20-60	20-60	
Percentage of Women Afflicted	0.608% approx.			

Table 7: District-wise Data on Percentage of Women with mental illness

This data is clearly indicative of the fact that community data reveals more women as suffering from mental illnesses. This corroborates the idea generated from secondary sources which also reveal the discrepancies in institutional and community data.

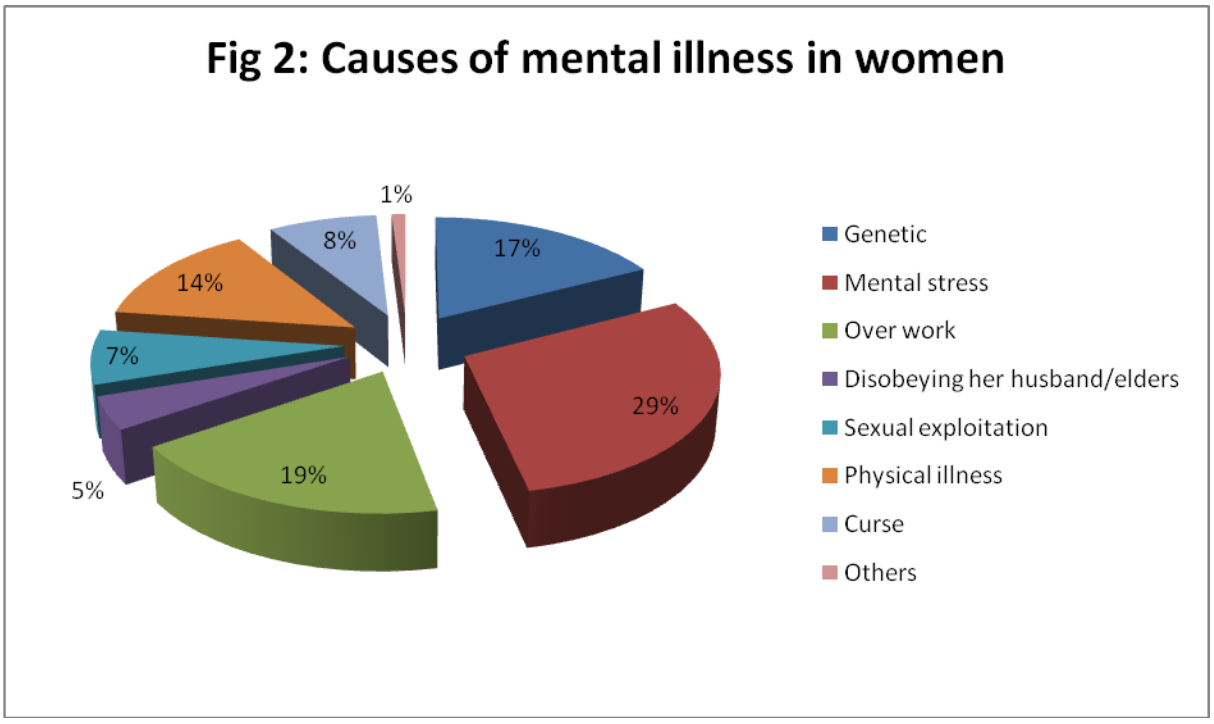
Having, thus averred that women are more vulnerable to mental illness, the following sections explore the influence of social and economic factors, which govern a woman's life, on her mental health.

B. Socio-cultural Factors and Mental Health

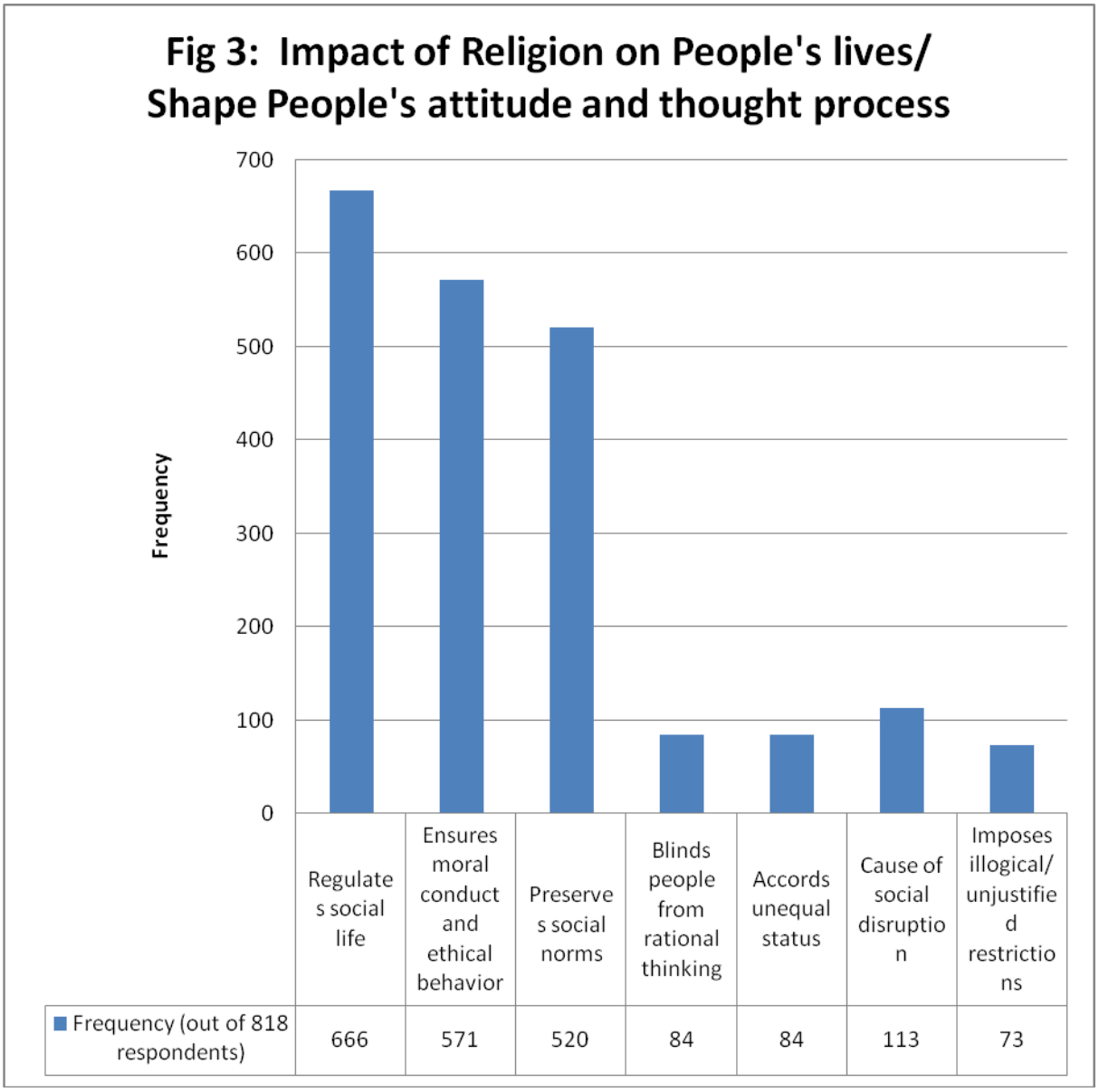
From a socio-cultural perspective the following may be considered as playing a dominant role in bringing about mental illness among women.

1. *Mental Stress*: Socio-cultural norms (mediated by religion and other factors) vary for men and women of a society. These factors which impose restrictions on women and accords them inferior status in society may often create mental stress. This mental stress disturbs the mental health of women and may result in psychoses of various kinds.

Data generated from the field reveals that mental stress, caused by several factors including those generated by socio-cultural norms have a bearing upon the mental health of women. Most respondents have responded in favour of this argument as is depicted in the figure below.



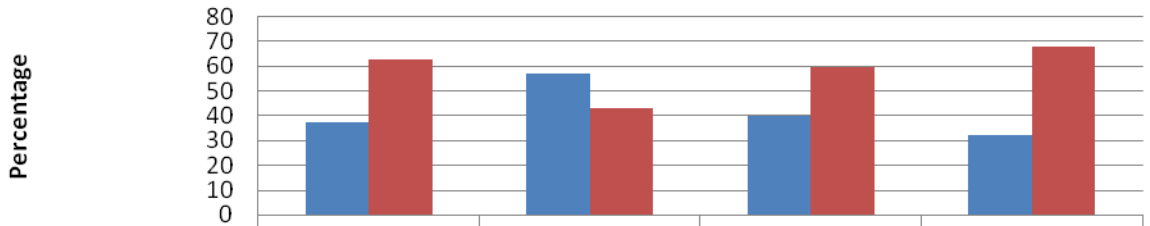
***2. Religion**:* Religion is an important socio-cultural determinant of the status and power that men and women yield in society. Religion shapes the thought processes, attitudes and has a strong influence on one's conduct. Data generated from the field is in sync with this argument as the following figure reveals.



Secondary data explicitly mentions that religious norms are favourably disposed towards men and is restrictive, to say the least, towards women. The sanctions placed upon women by religion create barriers towards their social participation, mobility and relegates them to inferior position.

The argument here is that such relegation impacts upon a woman's sense of dignity and self-esteem which could be distressful and impact upon her overall mental being. The following table is indicative of how religion restricts the participation of women in various activities.

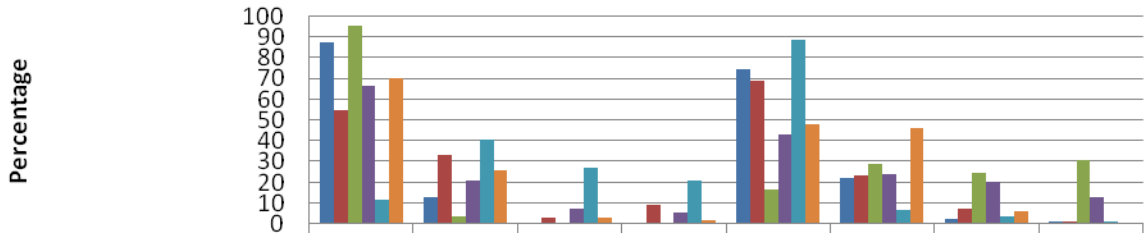
Fig 4: Religious restrictions on women



	Attending prayers in religious institutions (Temple/Mosque /Church/Namghar etc.)	Performing funeral rites	Participation of widows in auspicious occasions	Active role in religious rituals/ activities
Yes (in percentage)	37.4	57	40.1	32.1
No (in percentage)	62.6	43	59.9	67.9

This table suggests that the participation of women is far less in certain rituals (e.g. death rituals, purification rituals) which in traditional society are an exclusive domain of the men.

Fig 5 : Degree of participation of women/men in religious rituals/rites

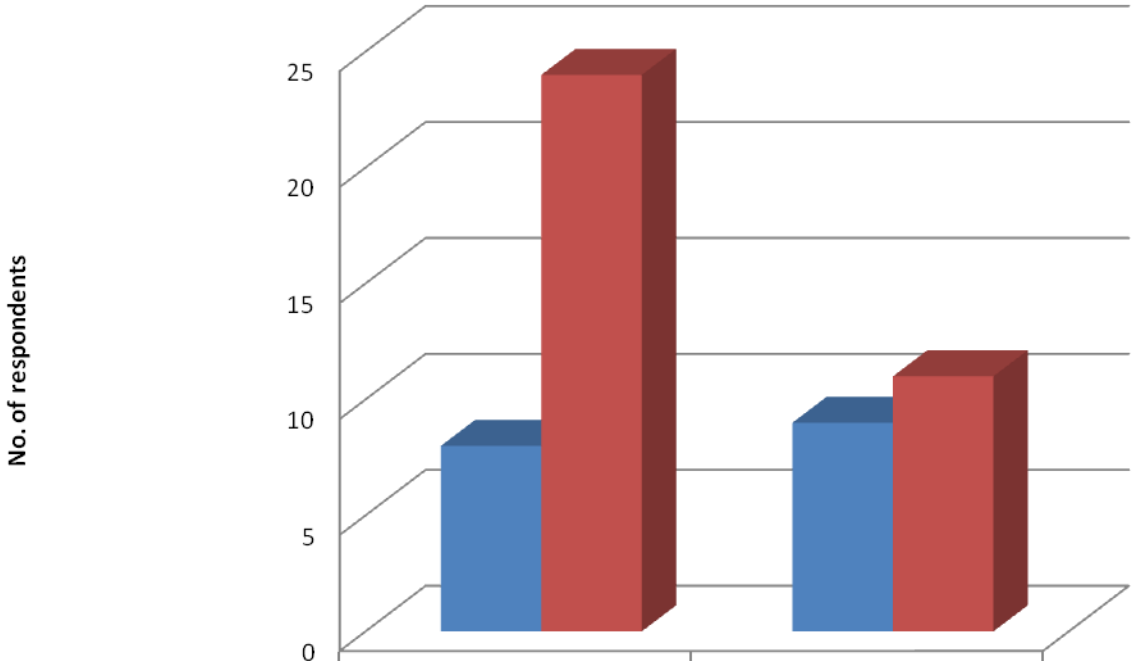


	Men				Women			
	Active Participation	Nominal Participation	Ancillary participation	Exclusion from participation	Active Participation	Nominal Participation	Ancillary participation	Exclusion from participation
Marriage rituals	87.1	12.5	0.4	0	74.1	22.2	2.5	1.3
Birth rituals	54.6	33.2	3.1	9.1	68.5	23.1	7.1	1.1
Death rituals	95	3.5	0.9	0.6	16.5	28.7	24.3	30.5
Purification rituals	66.3	20.7	7.5	5.4	43.1	24	20.3	12.6
Puberty rituals	11.8	40.2	27	21	88.4	7	3.6	1
Other Auspicious rituals	69.7	25.7	2.9	1.8	47.8	45.8	6	0.4

3. Marriage: Marriage is an important social event which as several studies have revealed cause mental distress among women. Many studies have revealed that mental illness is more prevalent among married woman than others. The cause of the same may be attributed to the fact that women possess less decision making power, enjoy a lesser status and autonomy, and have to shoulder more responsibilities in their husband's house than in their natal house. The factors, impact upon a woman's overall well-being and tells upon their mental health. A progressively deteriorating mental health would naturally graduate to mental illness.

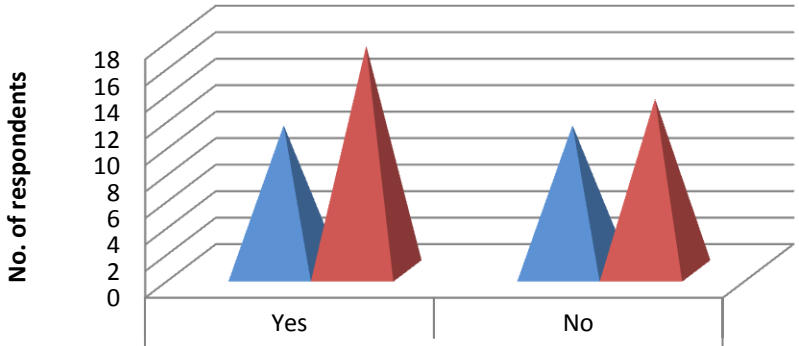
The following tables figuratively represent the voice of the community members who testify to the fact that a woman's overall position is affected after marriage, and most often than not their autonomy and position may be thwarted in their husband's house.

Fig 6: Decision making power in natal v/s in-law's house



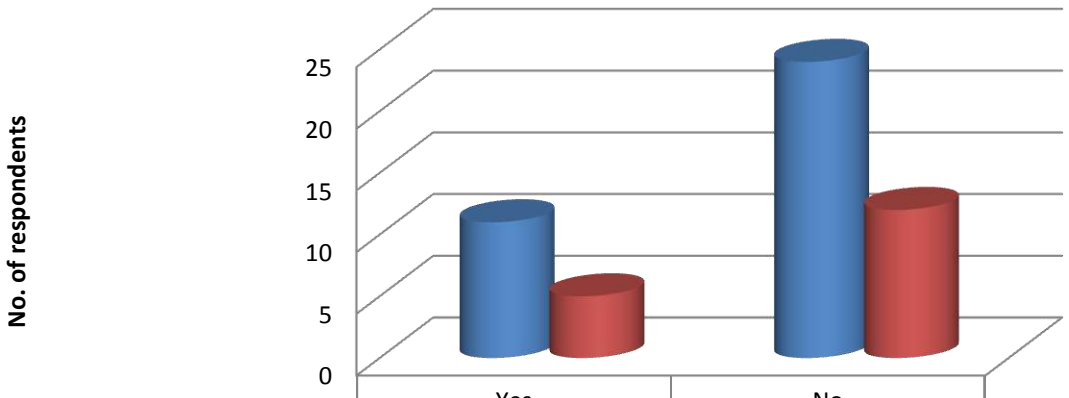
	Yes	No
Husband's house: Decision making power Yes	8	9
Husband's house: Decision making power No	24	11

Fig 7: Social status in natal v/s in-law's house



	Yes	No
Husband's house: Social status Yes	11	11
Husband's house: Social status No	17	13

Fig 8: Burden of domestic work in natal v/s in-law's house

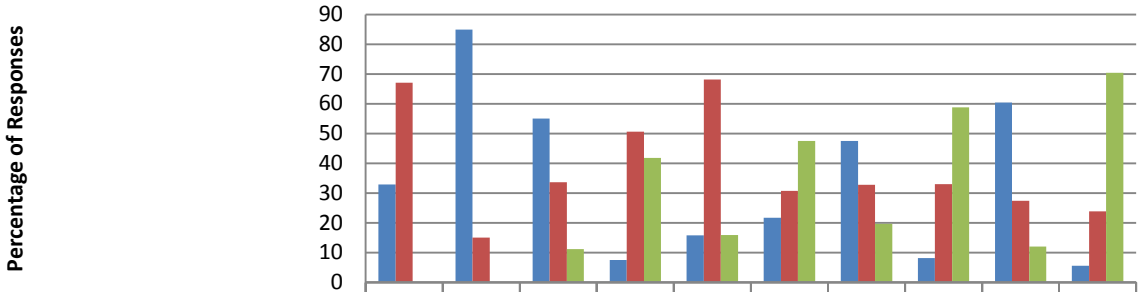


	Yes	No
Husband's house: Burden of domestic work Yes	11	24
Husband's house: Burden of domestic work No	5	12

Mental illness is stigmatised in society, owing to which women suffering from mental illness are adversely impacted by the same. Though both men and women are stigmatized, the brunt of the stigma is born by women. Social segregation, thwarted prospects of marriage and employment, limited social participation and mobility are some of the conditions that impair the social life of women afflicted with mental illness.

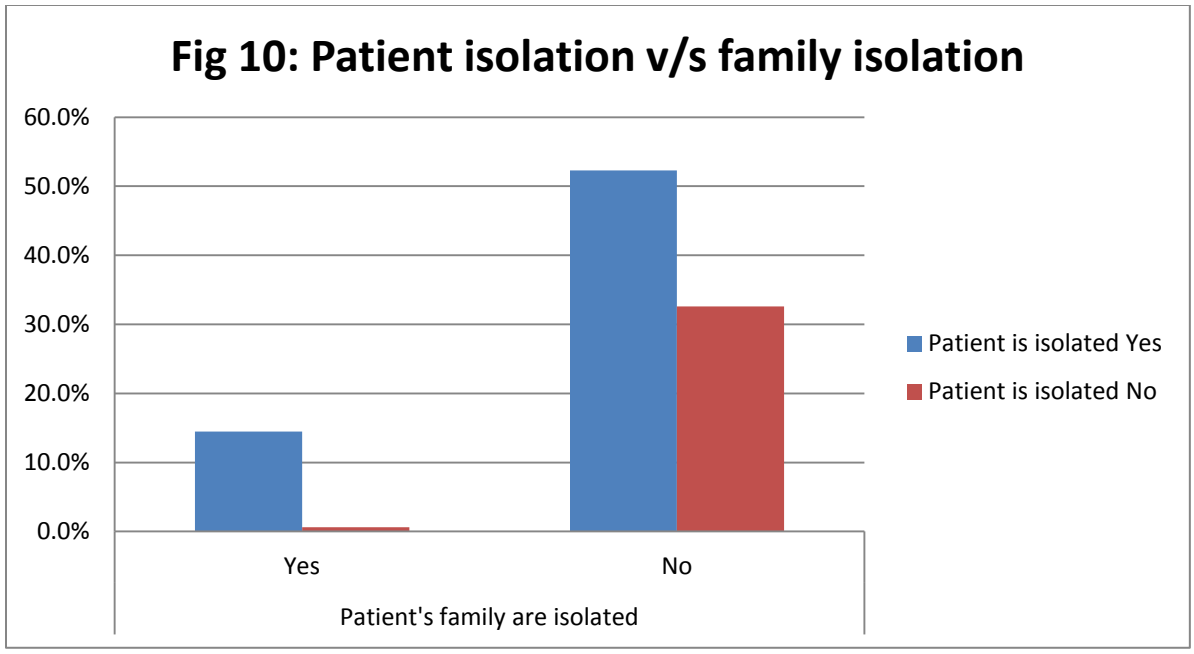
This table depicts how several aspects of a woman's life are impacted by her mental illness.

Fig 9: Impact of mental illness on family / patient

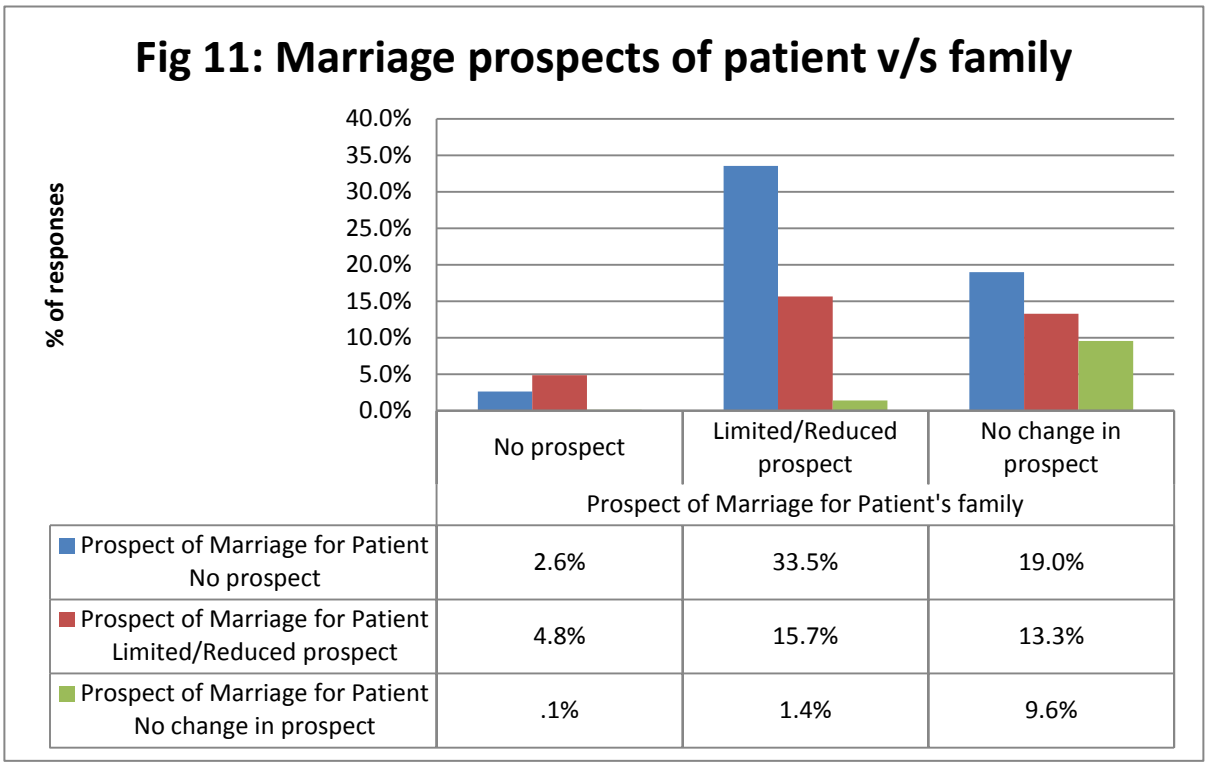


	Isolation		Prospect of marriage		Low social status		Participation in social activities (religious/ cultural)		Employment prospects	
	Patient	Family	Patient	Family	Patient	Family	Patient	Family	Patient	Family
No prospect / No	32.9	84.9	55	7.6	15.8	21.7	47.5	8.2	60.4	5.6
Limited (Reduced) prospect / Yes	67.1	15.1	33.7	50.6	68.2	30.8	32.8	33	27.4	23.9
Same as before			11.2	41.8	16	47.5	19.7	58.8	12.1	70.4

The following table reflects how on account of mental illness, the patient as well as the family of the patients face social isolation though the degree of isolation is more in case of the patients.



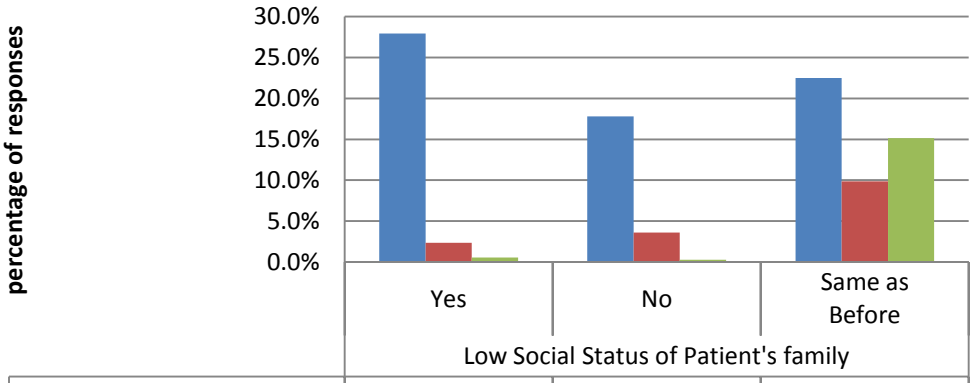
The following table is a depiction of how the prospect of marriage of patients is limited. The prospect of marriage of family members is also adversely affected as has emerged from the voices of community members.



Prospect of Marriage for Patient No prospect	2.6%	33.5%	19.0%
Prospect of Marriage for Patient Limited/Reduced prospect	4.8%	15.7%	13.3%
Prospect of Marriage for Patient No change in prospect	.1%	1.4%	9.6%

The table below reflects that the social status of the family and the patient as well as that of the family members is adversely affected.

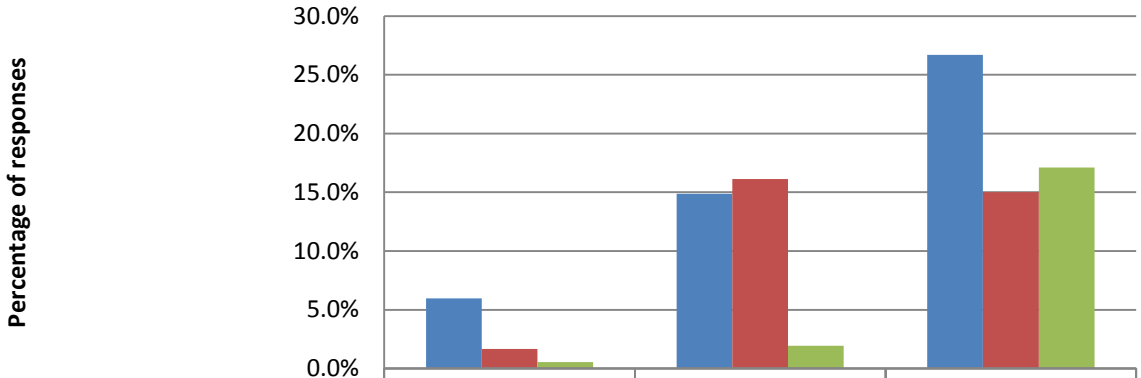
Fig 12: Social status of patient v/s family



	Yes	No	Same as Before
Low Social Status of Patient Yes	27.9%	17.8%	22.5%
Low Social Status of Patient No	2.4%	3.6%	9.9%
Low Social Status of Patient Same as Before	.6%	.3%	15.1%

The overall autonomy and participaton of patients of mental illness is also negatively impacted as the following data suggests.

Fig 13: Participation of patient v/s family in social activities

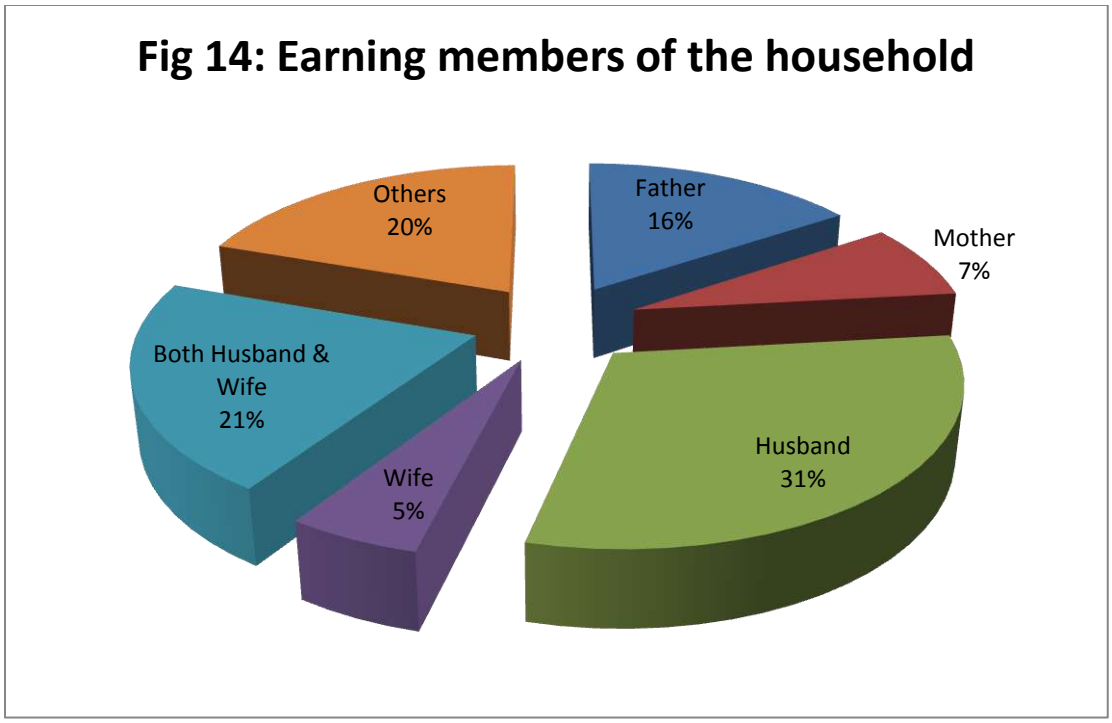


	No Participation	Reduced Participation	Same as before
Participation in Social activities No Participation	6.0%	14.9%	26.7%
Participation in Social activities Reduced Participation	1.7%	16.1%	15.0%
Participation in Social activities Same as before	.6%	1.9%	17.1%

C. Economic Factors and Mental Health

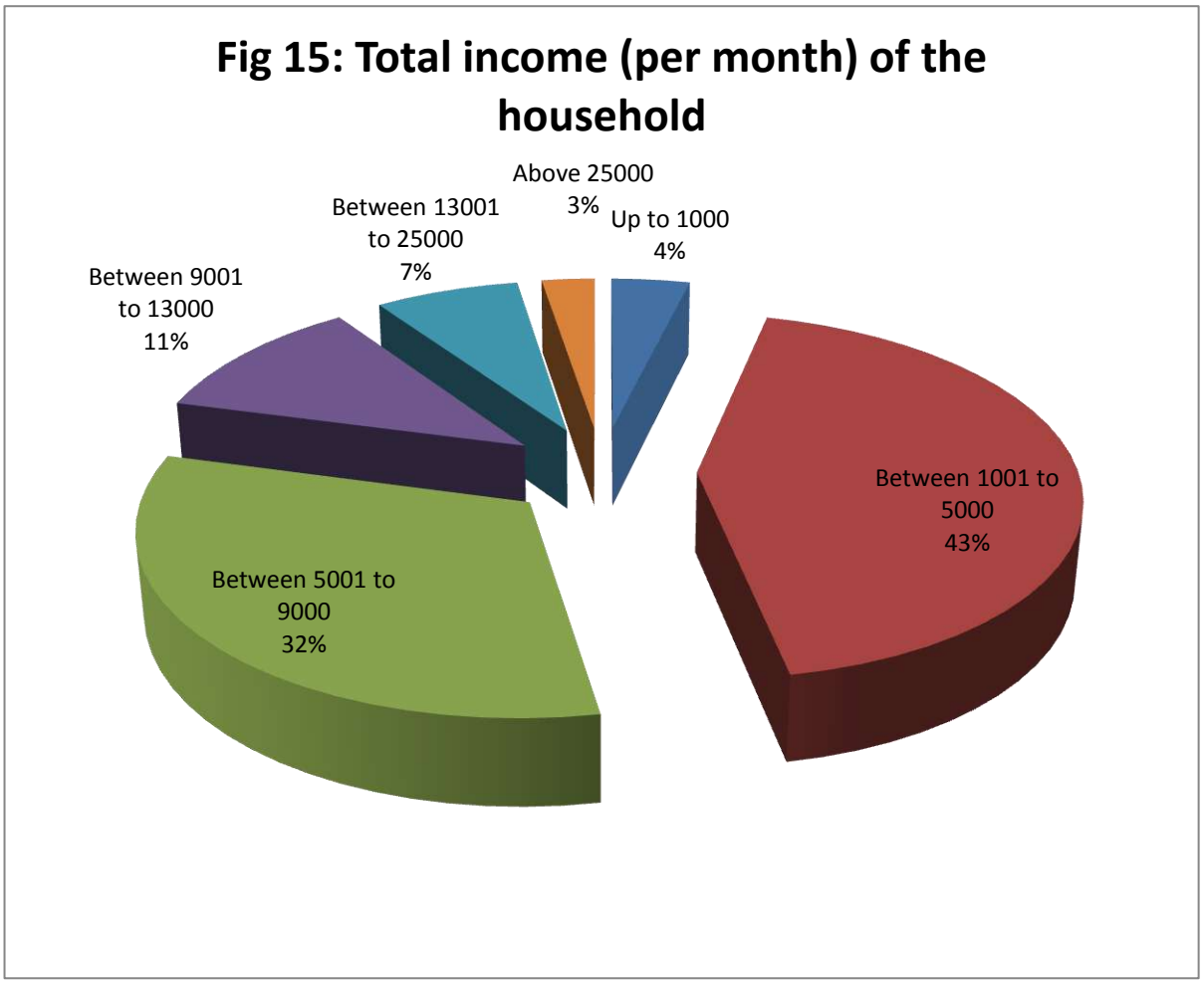
Poverty has an adverse implication with respect to mental illness as several studies have shown as the same has the potential to increase stress and frustration in life. Poverty is brought about by low income and inadequate access to resources which characterize the life of women more than that of men. Women's low economic status exposes them to several forms of stress, which in turn would have an effect in their mental health.

The following figure represents how the male is the earning member in the households surveyed and therefore accounts for the inferior economic status among women. Their economic status impacts upon their decision making power and authority. Low level of authority and autonomy, as several studies have pointed out, tell upon the mental health of women.

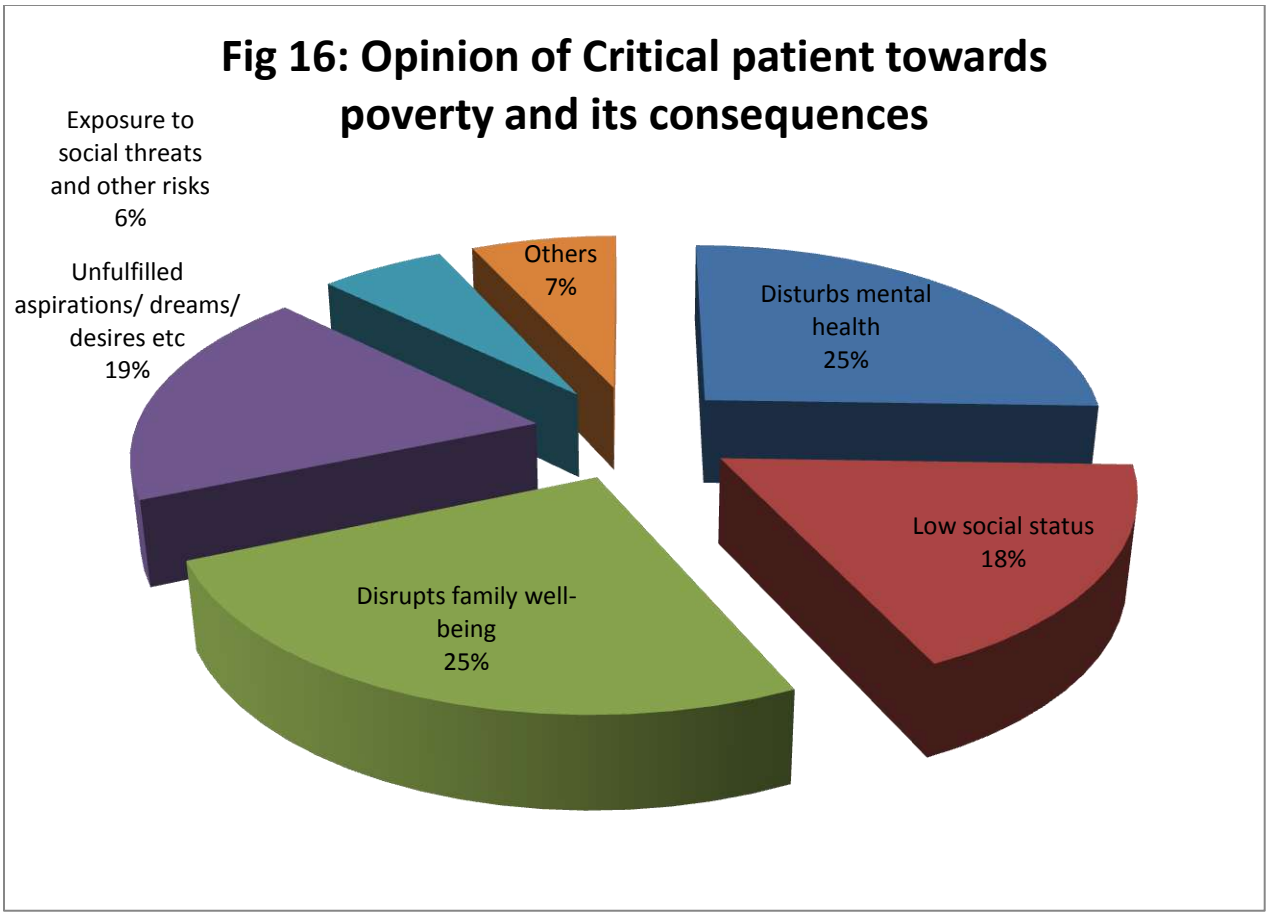


**Others represent brothers/distant relatives*

1. Handling financial strain: According to the study, the household surveyed belong to the low economic status group. Therefore the members of the household particularly the women faced the brunt of it.

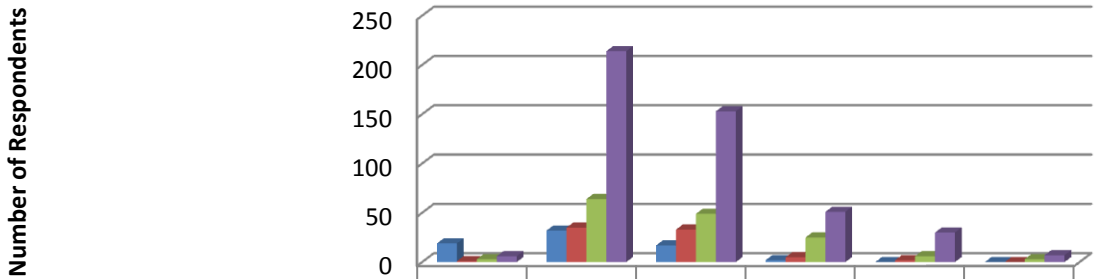


The figure below provides inputs regarding the patient's perspective of poverty and its bearing upon overall mental and physical health of family. Most respondents opined that poverty adversely affected mental health of family members.



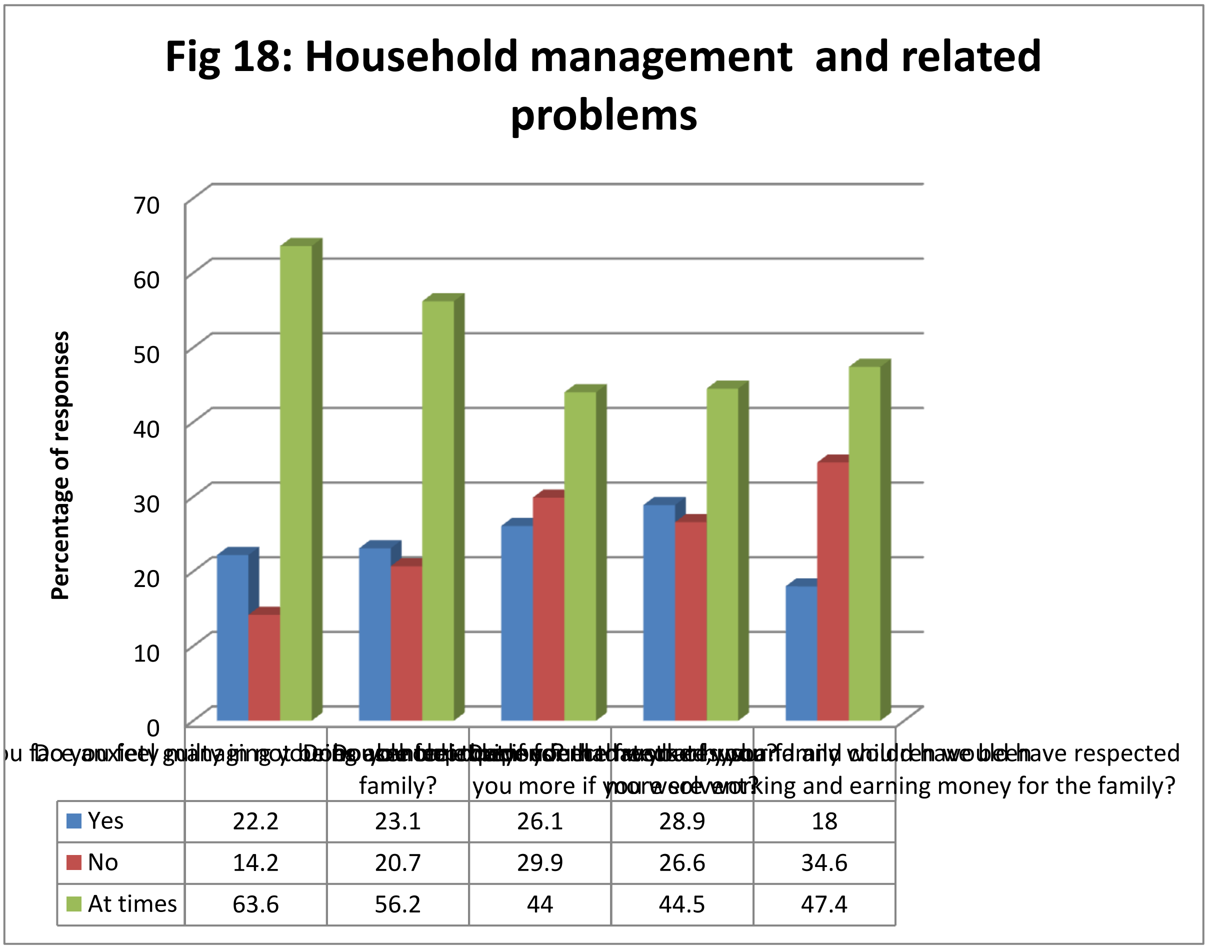
In these households, the women explained the nature of stress they faced on account of strained economic status of their household, as is shown in the following figure. Several works referred to have explicated the vulnerability of women to mental illness owing to the stress related with managing expenses within a limited income. The table reveals how the women experienced difficulty in providing for food, educational expenses and health related expenses. These factors create a sense of frustration and dejection, more particularly among women who feel responsible for taking care of family members. These stressors often disturb the mental health of the women.

Fig 17: Total monthly income and difficulties woman experience while running household

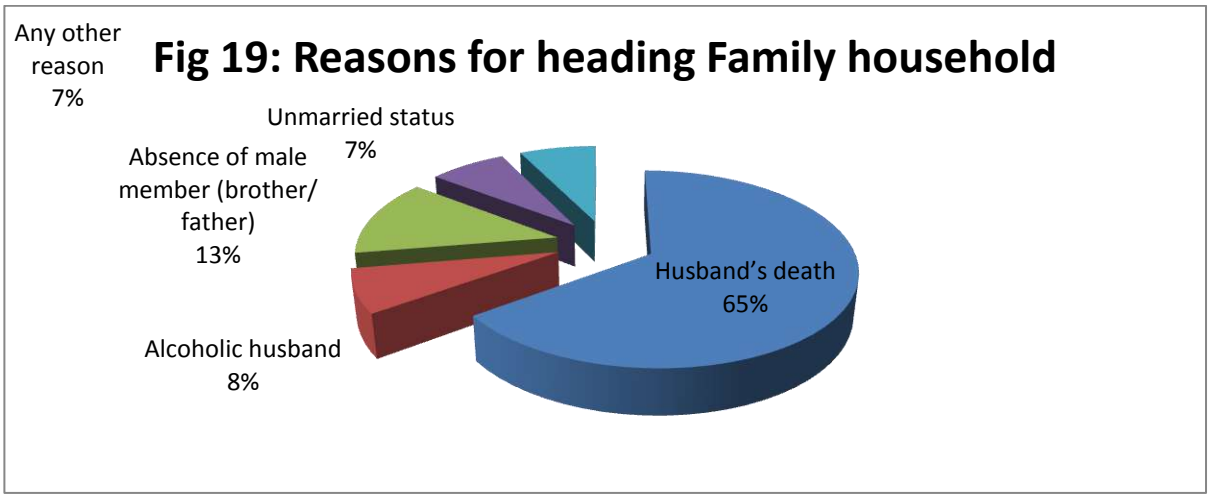


	Up to 1000	Between 1001 to 5000	Between 5001 to 9000	Between 9001 to 13000	Between 13001 to 25000	Above 25000
Difficulty in providing at least two square meals for the family.	19	32	17	2	0	0
Difficulty in providing education for the children.	1	35	33	5	2	0
Difficulty in covering health related expenses.	3	64	49	25	6	3
All of the above	6	214	153	51	30	7

The figure given below reveals how women experience guilt, anxiety and frustration in managing the household expenses within limited finance. These emotions experienced by women are negative in their essence and adversely affect the mental status of the same.

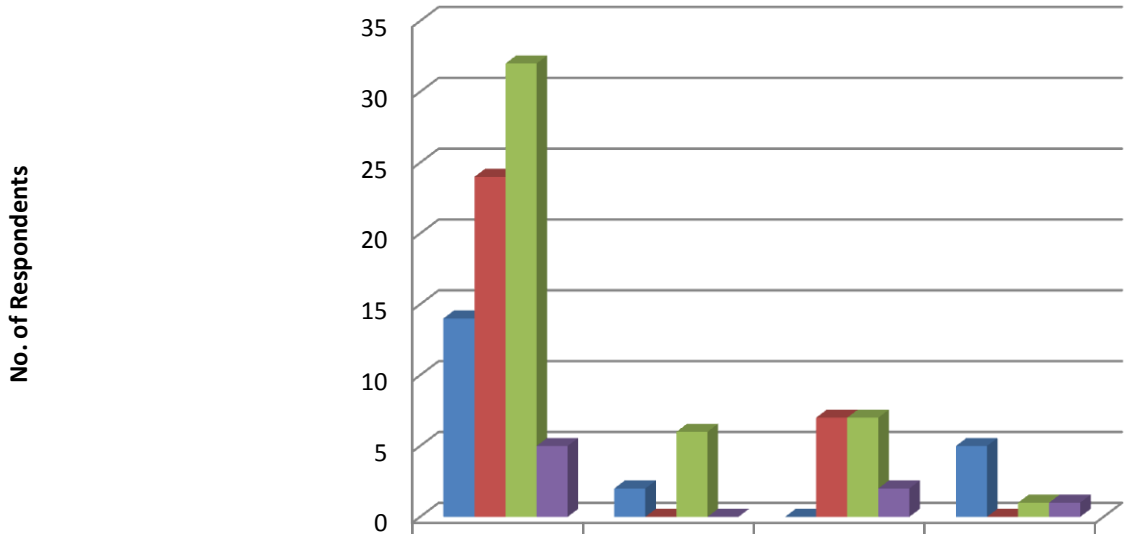


2. *Female Headed Household*: Households headed by women are more vulnerable to poverty as per the premise of '*feminization of poverty'.* The mental stress therefore compounds in such situations and would adversely impact the mental health of women. The figure below tells us how female headed households come into being, the causes in an order of priority *include death of spouse, followed by absence of male family member and single marital status.*



The data generated from the study reveal that, women who have to shoulder economic responsibility feel burdened in most cases. In addition to that, a sense of insecurity owing to the lack of spousal support also creates stress in the lives of such women and affect their mental wellbeing.

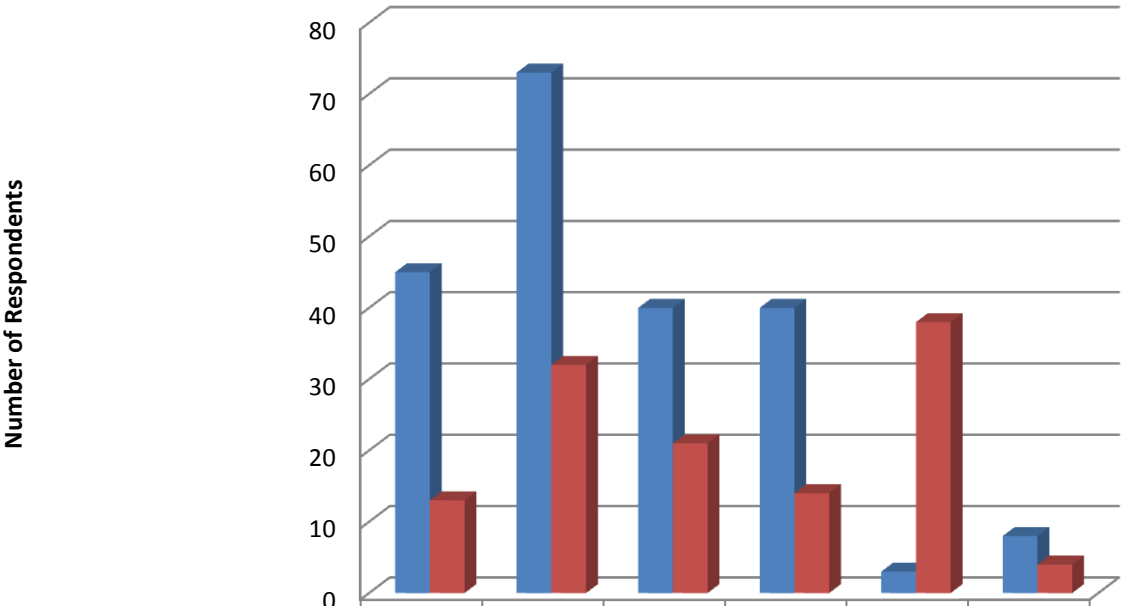
Fig 20: Experience and difficulties for women headed households



	Economic crisis	Social discrimination	Security issues	Any other
How do you feel about you being the head of the household? Empowered	14	2	0	5
How do you feel about you being the head of the household? Insecure	24	0	7	0
How do you feel about you being the head of the household? Burdened	32	6	7	1
How do you feel about you being the head of the household? Others	5	0	2	1

Further, the nature of work the women were involved in determined the amount of stress they experienced. Women who worked as daily wage earners experienced the maximum stress followed by those in agriculture and allied services, to be followed by the salaried employees, both permanent as well as casual. Work related stress also has been identified as a cause of mental distress among women. The wage earned by them, the respect at workplace and occupational related hazards all contribute to distress among women.

Fig 21: Nature of Work and related stress for working women

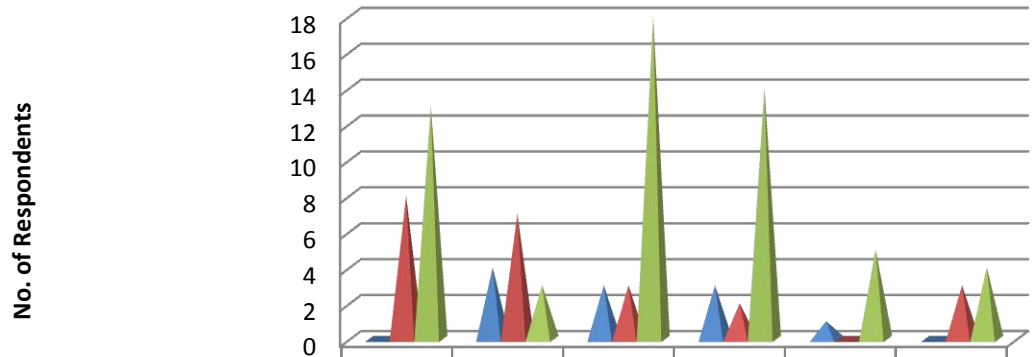


	Agriculture and Allied	Daily wage earner	Salaried Service(regular)	Salaried but casual	Unemployed	Others (Specify)
Does managing work and household create stress? Yes	45	73	40	40	3	8
Does managing work and household create stress? No	13	32	21	14	38	4

*Others include independent business

Mental illness among women has several adverse effects on the economy of the family. Firstly, it debilitates the member from engaging in gainful employment which impacts the household income. Secondly, it weighs upon the household expenditure, which in households of low economic status has greater ramifications. The patient's treatment is neglected owing to financial constraint. Moreover, it creates further distress among patients who feel that their condition is detrimental to the household's economy. Data generated from critical patients reveal that they at times experienced guilt owing to the expenditure incurred on their illness and its negative impact upon household economy. Further, they felt that poverty impacted adversely the mental wellbeing and social status of the family.

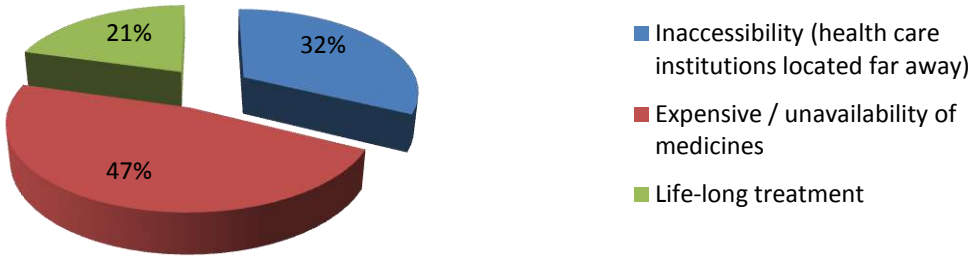
Fig 22: Critical Patient's guilty feeling about the expenditure spent on mental health and is her opinion towards poverty and its consequences



	Disturbs mental health	Low social status	Disrupts family well-being	Unfulfilled aspirations/ dreams/ desires etc	Exposure to social threats and other risks	Others
Does she feel guilty about the expenditure spent on her mental health? Yes	0	4	3	3	1	0
Does she feel guilty about the expenditure spent on her mental health? No	8	7	3	2	0	3
Does she feel guilty about the expenditure spent on her mental health? At times	13	3	18	14	5	4

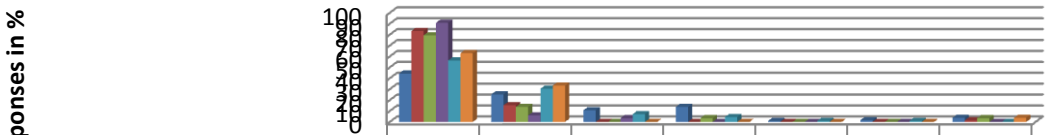
The expenditure incurred on treatment of the mentally ill is high as patients themselves have revealed and is represented in the following figure. Therefore, in families that pursue treatment for the patients find themselves in a crisis situation. Most often than not, the strain on economy does not permit the family to pursue treatment. The given figure is reflective of how the high cost of mental illness poses itself as a threat to household economic security.

Fig 23: Thought about cost of mental illness treatment



The table below clearly indicates how the treatment is availed in most cases when the cost of the same is small. As the treatment gets expensive patients and their families withdraw from treatment. The economic burden of mental illness is high, and therefore, is a determinant of whether or not treatment is availed.

Fig 24: Monthly cost of treatment (in %)

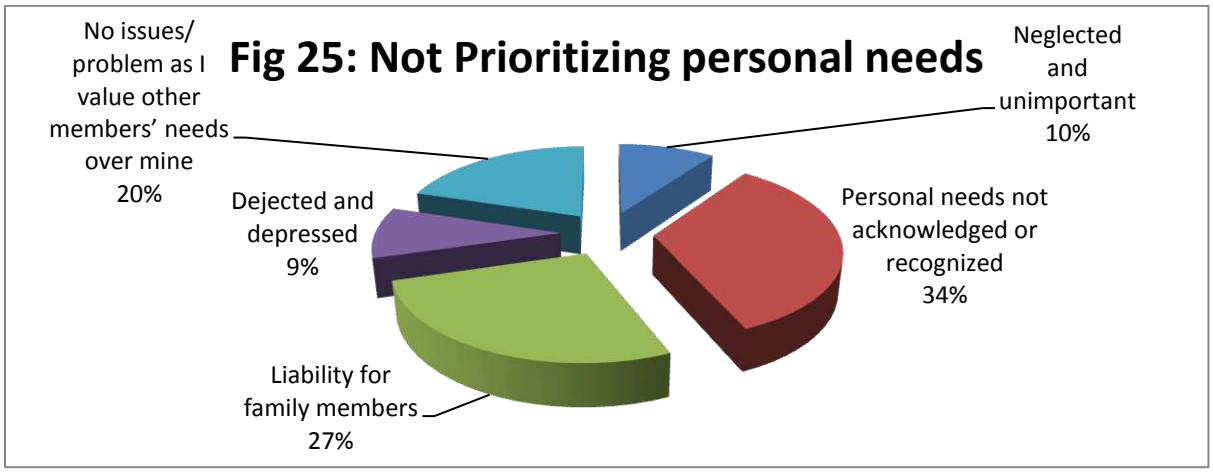


	Upto 500 INR	Between 501 INR-1000 INR	Between 1001 INR-1500 INR	Between1501 INR - 2000 INR	Between 2001 INR - 2500 INR	Between 2501 INR - 3000 INR	Above 3000 INR
Monthly Expenditure	44.3	25.2	10.7	13.7	0.8	1.5	3.8
Consultation	83.3	15.3	0	0	0	0	1.4
Test/ Investigation/ Diagnosis	79.3	13.8	0	3.4	0	0	3.4
Travel Cost	90.8	5.9	3.4	0	0	0	0
Medicines	56.3	30.4	7.1	4.5	0.9	0.9	0
Hospitalization/ Rehabilitation	63	33.3	0	0	0	0	3.7

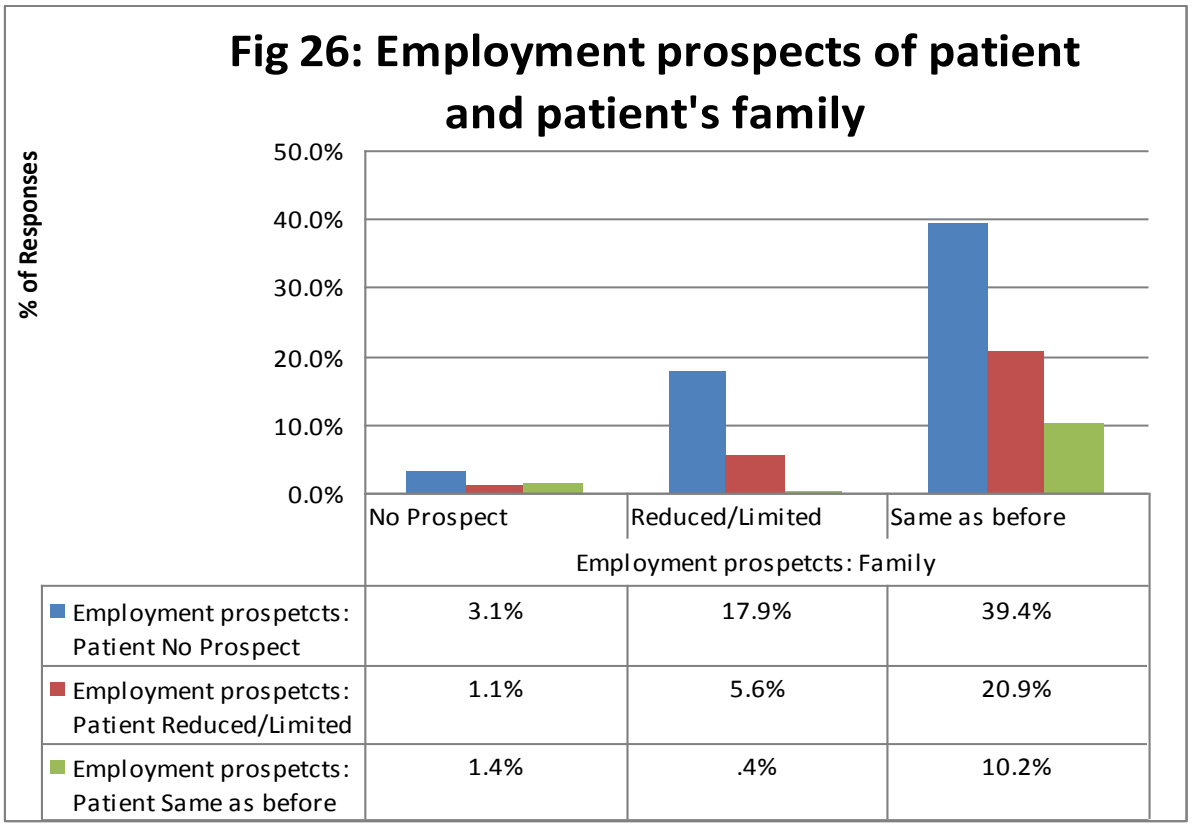
D. Social Response to Mental Illness

Owing to the stigma associated with mental illness as also the prejudices associated with the same the society, in most cases, reacts negatively towards the mentally ill. The women owing to their inferior social position are victimized more than men.

Social status of women in the society is far inferior to that of the men. In course of data collection, women were interviewed who expressed that owing to their inferior social status their personal needs and aspirations were neglected. The following figure is reflective of the same.

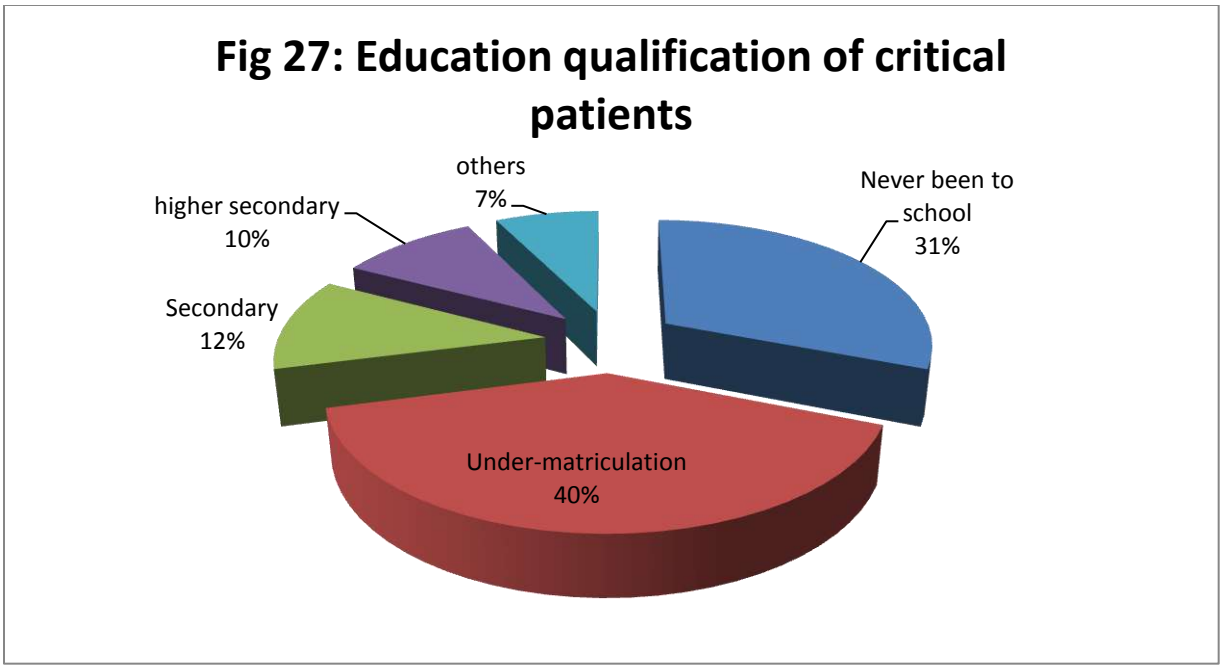


Further, the social space of the patients particularly that of the females shrank in the face of their Illness. This has ramifications both socially (as discussed under social impact of mental illness) as well as professionally. The figure below reveals that the community members have acknowledged the reduced employment prospect of patients (more than that of their family members).

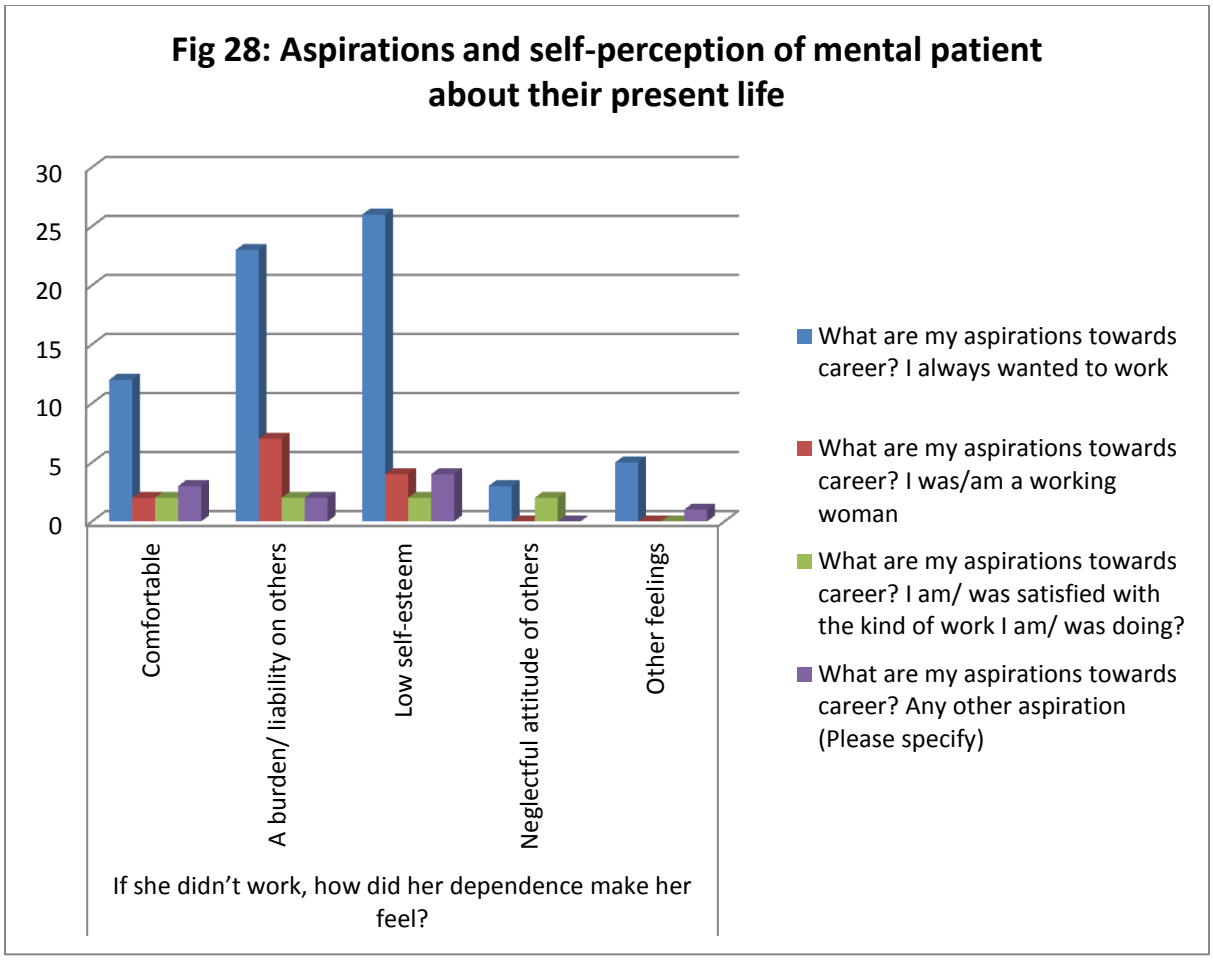


	No Prospect	Reduced/Limited	Same as before
Employment prospetcts: Patient No Prospect	3.1%	17.9%	39.4%
Employment prospetcts: Patient Reduced/Limited	1.1%	5.6%	20.9%
Employment prospetcts: Patient Same as before	1.4%	.4%	10.2%

Further, institutions of the society such as schools also limited their space for the mentally ill which is reflected in the figure below. The same reveals that most patients were under matriculation while most others had never been to schools. The absence of education would relegate patients as liabilities and would lead to further victimization.

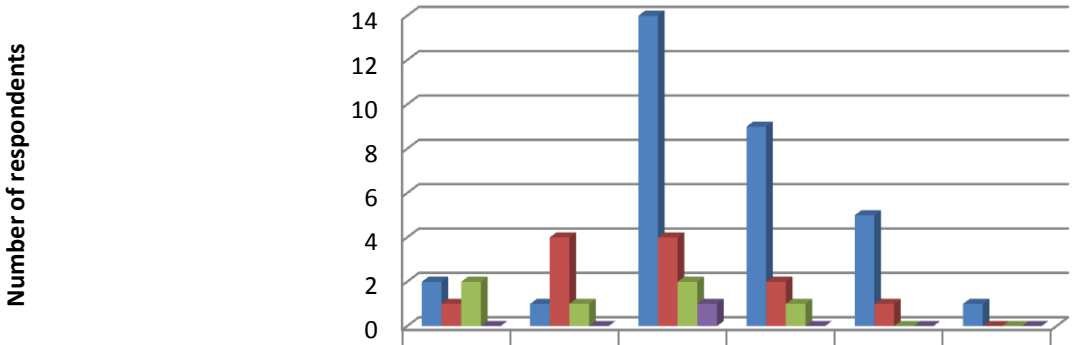


The aspirations of the patients remained thwarted owing to the prejudices of a society that was attuned to view the mentally ill as deviants and therefore harboured a negative impression about the same. The figure below represents that most patients aspired for gainful employment, however only a small percentage of the same were actually employed.



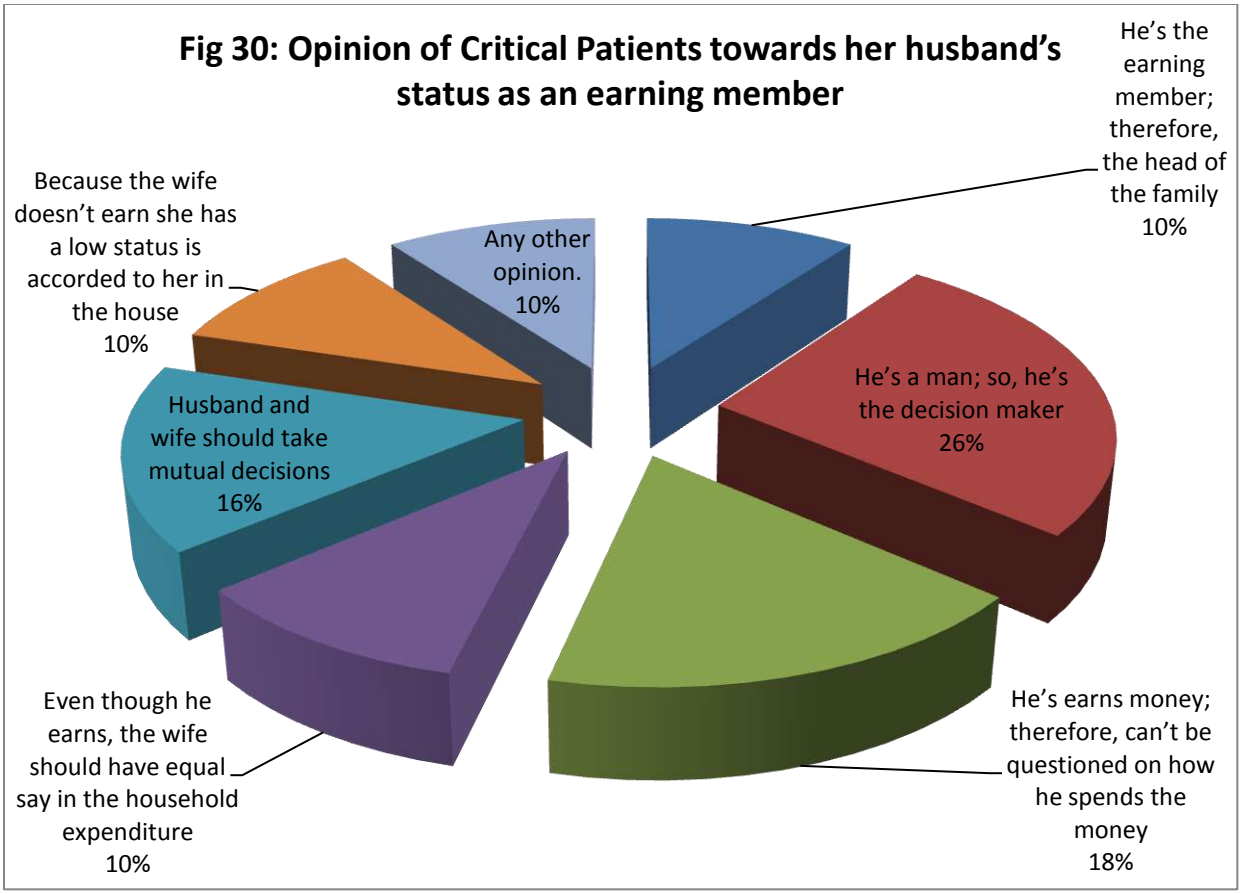
Those patients, who were working, however complained of discrimination, unequal treatment and exploitation. This is also indicative of the vulnerability that mentally ill patients are exposed to in negotiating the public domain. The figure below indicates the same.

Fig 29: Relationship between aspirations and work experiences of critical patients



	I received equal treatment as others (male counterparts/ other cultural factors)	It was a satisfactory and congenial atmosphere	Faced discrimination	Low wage	Exploitation	Others
I always wanted to work	2	1	14	9	5	1
I was/am a working woman	1	4	4	2	1	0
I am/ was satisfied with the kind of work I am/ was doing?	2	1	2	1	0	0
Any other aspiration (Please specify)	0	0	1	0	0	0

Further, the social neglect faced by women make them insecure and unconfident. Thus most patients develop a dependency syndrome towards their husbands and justify their authority and power in family matters thereby undermining their own dignity in their homes. The following figure is representative of the same.

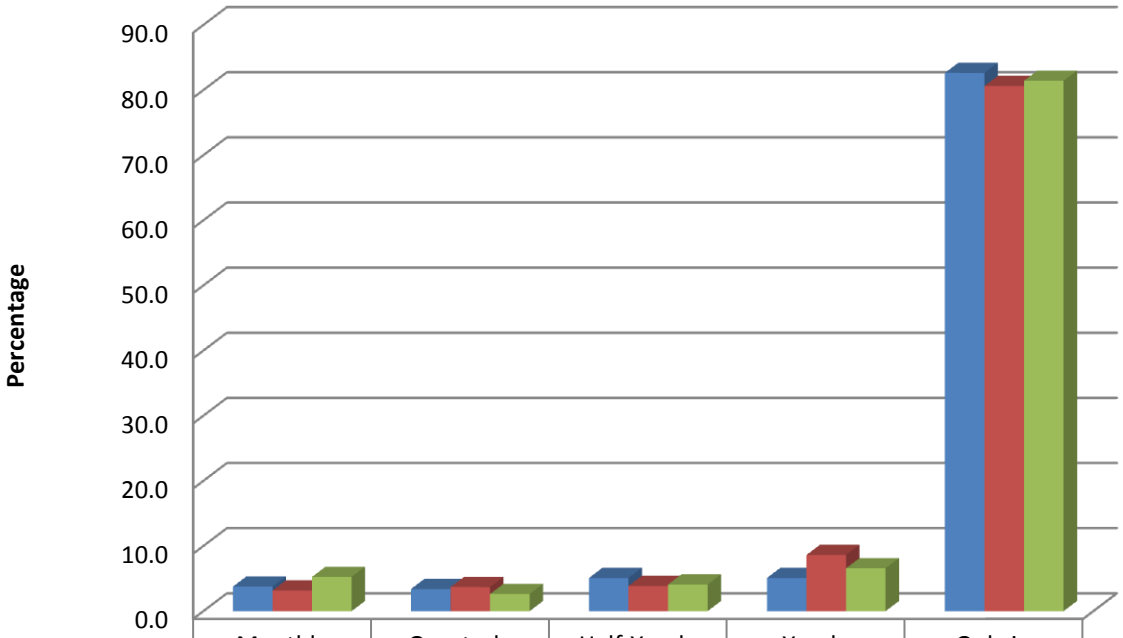


E. Physical Health and Mental Health

Physical health shares an integral relation with mental health. It has often been observed that chronic physical illness impacts the mental health of individual. In the Indian context, owing to the low social status of women their health issues are generally neglected which leads to prolonged suffering and may impact mental health.

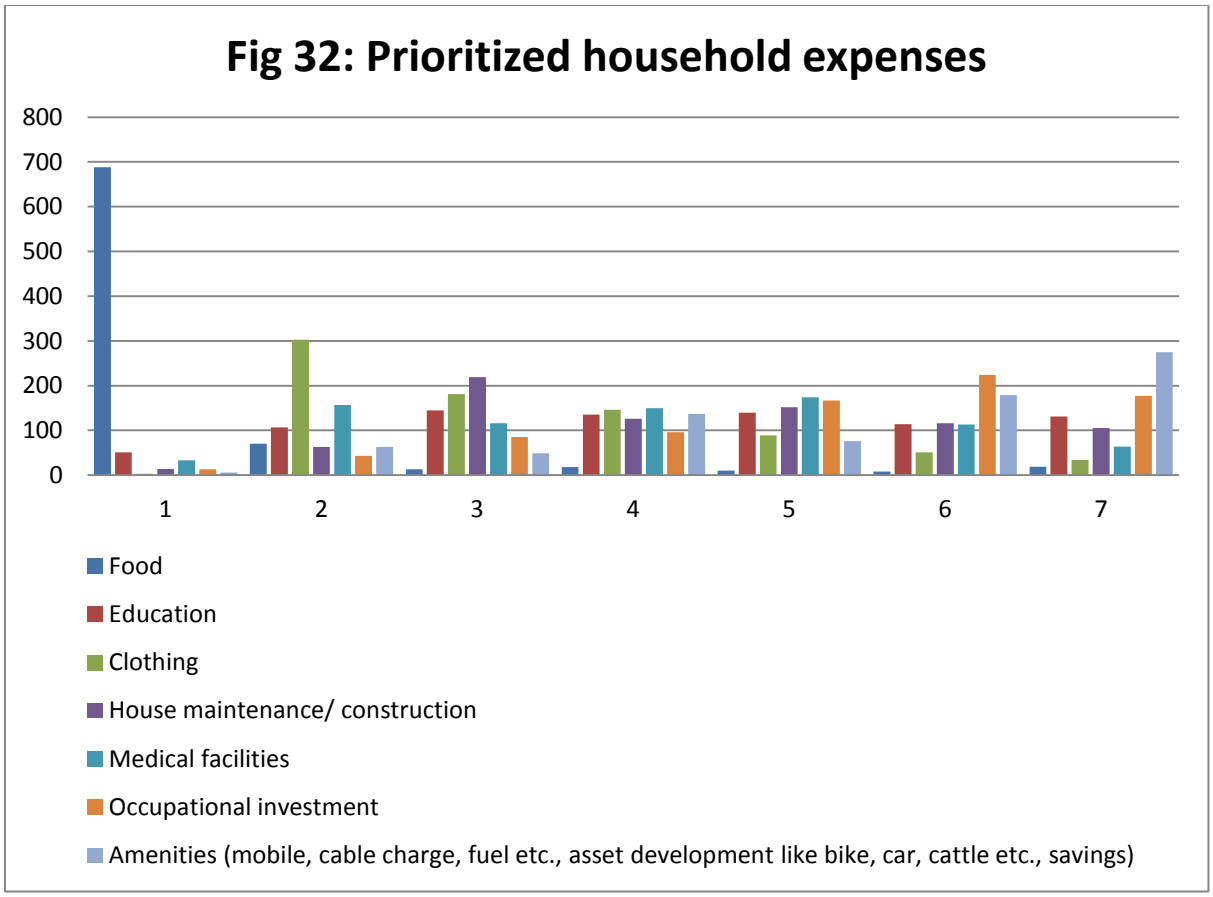
The data reflected in the figure below shows how routine health check-up is a rarity among community members, where a visit to hospitals is occasioned by health emergencies. This situation is relatively more adverse for women who, as several studies have revealed, have a predisposition for morbidity owing to lack of nutrition, physical exertion and other factors. Needless to mention that neglect of health issues may exert negative influence on physical well-being and correspondingly on mental well-being of individuals.

Fig 31: Visits to PHC/ Hospitals relating to health



	Monthly	Quarterly	Half-Yearly	Yearly	Only in Emergency
Husband	3.8	3.4	5.1	5.1	82.6
Child	3.2	3.7	3.9	8.6	80.6
Wife/Mother	5.3	2.6	4.1	6.6	81.4

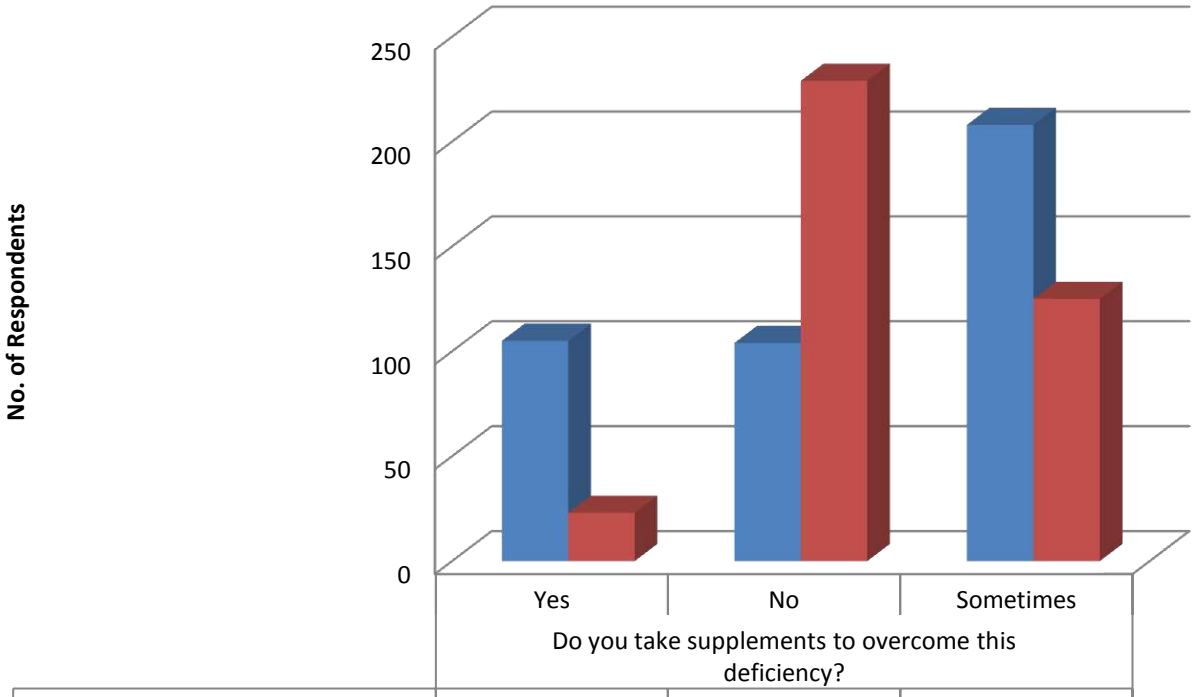
From the data generated from the field, it was evident that health care was not a priority, where providing for food, clothing and then education weighed over health concerns. The figure below is a depiction of the low priority accorded to health issues. Prolonged suffering from physical ailment cause psychological problems and this veritably explains the relation between physical health and mental health.



The neglect of physical health issues is further reflected in the figure provided below. The data here reveals that though community members are aware of the health issues common among women, they do not take appropriate measures towards the same. The point here is that neglect of health issues is common particularly among women and this neglect, when is prolonged over a span of time will leave its dent on mental health.

Community members do not reflect an understanding that physical health condition may influence mental health as well as is evident from Figure 2, where only 16% of respondents have acknowledged the connection between physical and mental well-being, while other causal factors had been cited by them as contributing to mental illness.

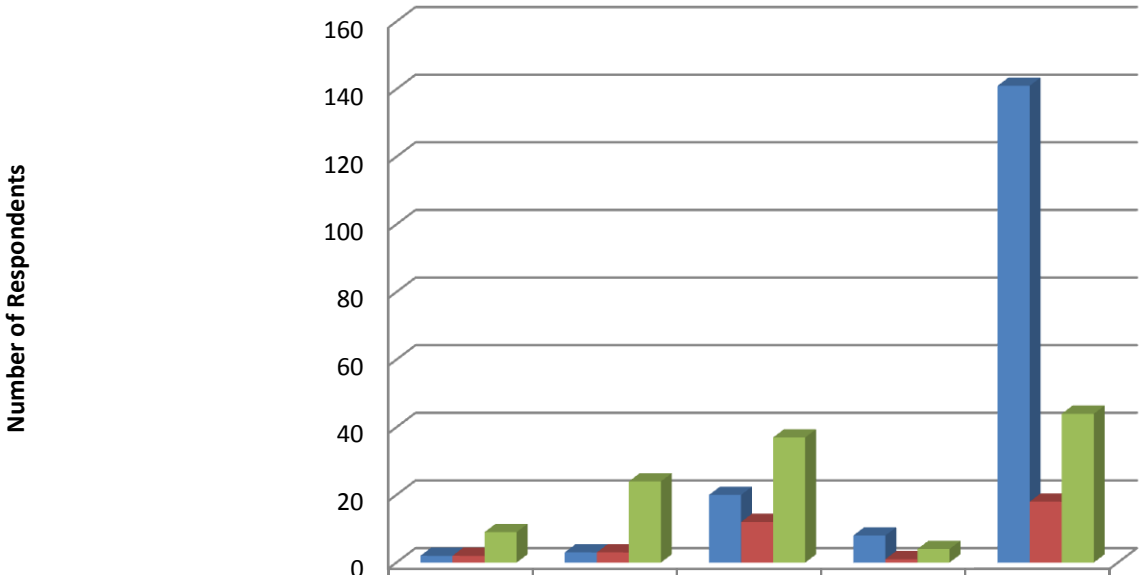
Fig 33: Deficiency awareness and supplement intake



	Yes	No	Sometimes
Are you aware that anemia, calcium deficiency, malnutrition are common among young and middle -aged women? Yes	105	104	208
Are you aware that anemia, calcium deficiency, malnutrition are common among young and middle -aged women? No	23	229	125

Another aspect that warrants exploration is the physical hazards women are exposed to in workplace. Working women who hail from low socio-economic status have been observed to engage in the unorganized sector where the work related hazards abound. Women engaged in work where work related hardships abound reflect poor physical as well as mental health. Women though are exposed to physical hazards in workplace, which include pollution, burdensome activities and unhygienic work condition to name a few. These aspects put the physical health of women to risk and also negatively influence their mental health. The following figure indicates the hazards women are exposed to in their workplace.

Fig 34: Relationship between physical health hazard in workplace and work-life satisfaction



	Pollution	Unhygienic Condition	Overloaded work burden	Others (specify)	None
Are you happy/ satisfied by the work that you do? Yes	2	3	20	8	141
Are you happy/ satisfied by the work that you do? No	2	3	12	1	18
Are you happy/ satisfied by the work that you do? Can't say	9	24	37	4	44

F. Institutional Response to Mental Illness

The data provided by several community surveys reveal that, prevalence of mental disorders in India is 6-7% for common mental disorders and 1-2% for severe mental disorders. Thus, it is evident that in institutional response towards the same must be adequate enough respond effectively to the emerging issue. Mental illness is a debilitating condition that hampers an individual's productivity and sense of dignity. The problem is further compounded by the social prejudices and myths which conditions people's attitude towards the mentally ill and in turn leads to victimization of the patient. The nation should take cognizance of the fact that members

of the society rendered unproductive due to mental illness would in time effect the overall productivity of the nation as a whole. Therefore, institutional measures should be strengthened to respond to the issue of mental illness.

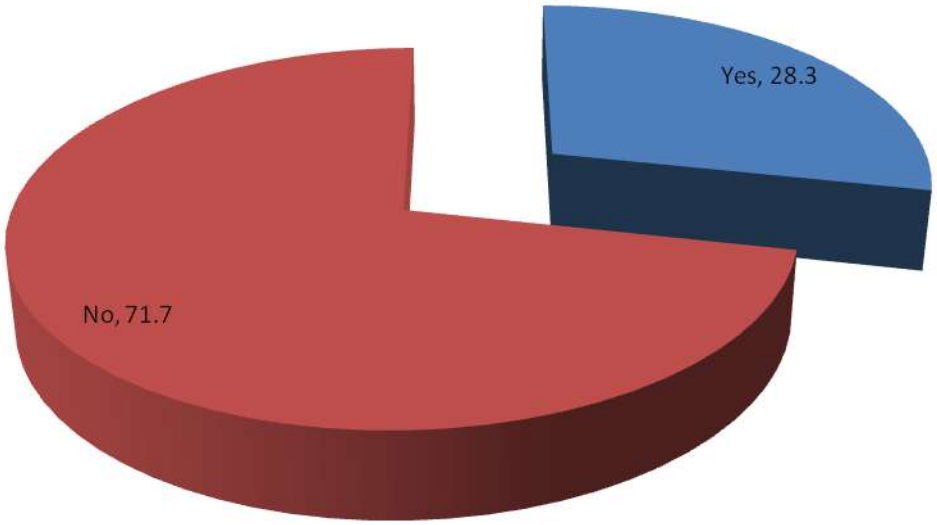
Institutional lacunae: The study conducted on hospitals of Assam has not yielded much data, owing to the restrictive accessibility to the same. However, it has been observed that LGB Regional Institute of Mental Health is the only institute in the NE dedicated exclusively to mental illness. The other hospitals have psychiatric units which need to be strengthened in terms of staff, equipment, medicines and other essentials.

Further, the budget allotted for health is oblivious to metal health issues and needs, which as has emerged from interviews with some health practitioners, is one primary reason that institutes of mental health and psychiatric units of hospitals have not developed much.

Paucity of trained psychiatrists and lack of sensitization among institutional staff was observed in some cases which warrant attention.

Institutional care v/s traditional healing: Further the community member's attunement towards traditional healing is not only on account of superstitions associated with mental illness, but also because the institutional care is expensive, inaccessible and isolates the person. Such mode of treatment lacks in community value. The figure below reveals the prevalence of mental illness in societies and that a sizable percentage of the population reject institutional care in favour of traditional practices.

Fig 35: Practices in your religion that can claim to heal mental illness



Sensitization and Awareness generation: Institutional data generated has shown that some sensitization programmes are conducted with hospital staff to condition their attitude towards the mentally. However, the same are few and far between. Moreover, community sensitization is also not very common in the area s surveyed. This calls for a concerted plan of awareness generation which will have collateral advantages, for instance positively influence community attitude towards institutional care, dispel myths related to mental illness and thereby influence the social space accorded to the mentally ill.

Women and Institutional Care: It was observed that less women availed institutional care. This fact is influenced by women's inaccessibility to institutional care and more importantly because the institutional environment may be perceived as inimical by the patients. This warrants that institutional response is more gender sensitive in addressing the specific needs of the female patients.

Rehabilitation and Integration: It is important that institutional care takes cognizance of the importance of rehabilitation and reintegration of the patients into mainstream society, rather that isolating them from the society. In this regard, non-governmental initiatives should be merged

with government services in ensuring the same. In the institutes surveyed this aspect was either ignored or only partially addressed.

INDIAN MENTAL HEALTH BILL, 2013 - A CRITIQUE

A universal phenomenon and social reality, mental illness has for long been considered a stigma in society. While searching for the 'most acceptable' definition of mental illness for decades and amidst varied range of dialogues, activities, programmes, bills, laws and discursive texts with regards to mental health on various platforms, mentally ill persons are still today alleged as the 'others' in society. For somebody a mentally ill person is a burden, and for others he or she possibly is a 'curse', 'useless beings' or 'unwanted'. So, any discussion of 'mental illness' must address itself to three simultaneous projects: the intensive appraisal of the causes of mental illness inclusive of socio-cultural, political and economic causes apart from bio-medical causes both in men and women; institutional amenities available for the patients such as hospitals, rehabs, asylums- their outreach, available manpower, facilities and services provided and a critique on the aspects of protecting rights of the mentally ill persons as included in any mental health bill or as endorsed by any law. In context of a country like India where the socio-cultural and politico-economic mosaic is composed of monolithic groupings and sub-groupings, these three projects require special focus and address. This particular critique is directed towards the the third project.

In the pre-independence era, Indian laws were implemented based on colonial conception and the institutions for mentally ill too were operational on the ideas and practices common in England and Europe. If we trace back in history and carefully go through the earlier laws revolving the mentally ill, it will be realized that the laws had a slant towards ignoring the aspect of rights protection of the mentally ill people. For instance, the Indian Lunatic Asylum Act, 1858 and the Indian Lunacy Act, 1912 ignored human rights aspects and concentrated mainly with the custodian issues. In that era the prime focus of any initiative revolving mentally ill persons was not to restore their health back or protection of their human rights, rather the initiatives had a slant towards separating the mentally ill people from the mainstream society with the conception that they are threats and dangerous to the not 'mad' section of the society. This detaching of the 'abnormal ones' from society certainly refers to a structural domination and a suppression of the mentally ill persons often through violent measures leaving no hope for them to recover from

their ailment and to live a dignified life with care and respect just like any other 'normal' person in society. Even during the initial years of pre-independence era, the colonial mental health system was still prevalent and the treatment provided to mentally ill people was asylum based where the concentration was custodial rather than care giving. However with time and need, mental health priorities were eventually realized and in current times, attempts have been made to bring amendments dictating those priorities in bills, policies as well in practice.

The recent Mental Health Bill, 2013, also called Mental Health Care Act, 2013 which has included many provisions and unprecedented measures aimed towards a sea change for the betterment of the mentally ill people. Worth-mentioning provisions such as right to access to mental health care and treatment run or funded by the government, refund of money to patients in case of private services availed due to lack of public health facilities in a district, essential psychotropic medicines free of cost, providing a more comprehensive definition of mental illness encompassing various mental conditions, cutting down of formalities during emergencies, decriminalizing suicide attempts are a part of this bill which were previously not included in the Mental Health act- 1987. One can say that the recent bill seems to be positively framed in the spirit of the United Nations Convention of the Rights of Persons with Disabilities (UNCRPD).

However, despite the positive features what remains a prime concern is the fear that all these remedial and revolutionary measures included in the Mental Health Care Act, 2013 (MHA, 2013) would simply remain golden words in documents and paper. The reason for such a thought is the over ambitious nature of the bill which ignores the ground realities that need to be checked first so that such an act could be successfully implemented with the highest of its impact in a vast country like India. It also underlines a over-inclusive definition for mental illness conveniently ignoring the fact that there is a wide prevalence of stigma in society and with such a definition the sentiments of patients as well as their families might be hurt. There is no mention about the huge resource-mobilization required to realize various assurances that the Bill comes up with. Moreover, in absence of penal provisions for the government functionaries not performing duties it is unlikely that they would efficiently extend various promised services to the beneficiaries. The patients and families will also be not able to seek relief through courts of law.

There are also many instances in society where people have been labelled 'mad' due to personal interests or hidden agenda of some others. Nothing has been said in the bill towards safeguarding

such victims or recognizing true cases of mental illness and punishment for deliberate selfish attempts by people to label others mentally ill.

CONCLUSION

The present study was undertaken with the view to establishing the connection between mental illness and socio- cultural and economic factors. The intent of the study was to expand the scope offered by bio-medical approach to mental illness, which locates the causal factors in the body of the patient, and the psychological model, which traces the cause of mental illness to the mind, by adding one more dimension to the same, that is the sociological approach, which identifies social factors as creating mental distress among people. The argument here is that a holistic approach to mental illness ought to integrate the perspectives of the three approaches to be able to address the issue in a holistic manner.

Further, the study has attempted to link the socio-economic factors with the mental illness among women, as women have been revealed to be more vulnerable to mental illness. The study has explored in details how socio-cultural and economic factors affect the mental health of women making them more susceptible to distress. The intent here is to draw the attention of service providers towards the women as a more disadvantaged group with respect to mental illness and also to gender sensitize the mechanisms of redressal.

Further, the institutional response to mental illness has been studied to gauge whether the same can adequately address the issue. The lacunae and the scope for improvement have also been suggested in the context.

It is felt that the study should be carried on to include the remaining districts of Assam. Moreover, community specific data should be generated rather than attempting a sweeping generalization as Assam represents a multi-cultural context where each community can be distinguished from the other on the basis of their ethnic practices and values.

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Manpower Trained in the Project:

- Ten (10) Field assistants and one (1) Data Entry Operator were trained in the project.

Abstract:

Gender casts a pervasive influence on many aspects of life, including access to resources, methods of coping with stress, mode of interaction with others, self-evaluation, spirituality, and expectations of others. These factors have the potential to affect mental health either positively or negatively. Research conducted in the field of Gender and Mental Health reflects that socially constructed differences between men and women in roles, responsibilities, status and power, interact with biological differences between sexes to contribute to difference in the nature of mental health problems. A large number of studies provide strong evidence that gender based difference contribute to higher prevalence of depression and anxiety disorder in girls and women when compared to their male counterparts. The lower self-esteem of adolescent girls , the feeling of a lack of autonomy and control over one's life, socially determined gender roles and responsibilities place women far more frequently than men, in situations where they have little control over important decisions concerning their lives. Gender determines the differential power and control men and women have their social position, status, treatment in society and their susceptibility and exposure to specific mental health risks. Pressures created by their multiple roles, gender discrimination and associated factors of poverty, hunger, malnutrition; domestic violence and sexual abuse combine to account for women's poor mental health. Most sociologists accept that female roles are relatively restrictive and oppressive, and they tend to keep their frustration and anger to themselves. Hence women are more likely victims of depression and anxiety. North East India is the most neglected area in terms of health sector. As per the data from the National Survey of Mental Health Resources conducted by the Directorate General of Health Services, Ministry of Health and Family welfare, Govt. of India in 2002, which was published as an Annual Report (2008-2009) of LGBRIMH, Tezpur, the total population of North East region was approximately 40 million and out of these about 3, 85,000 people were estimated to suffer from major mental illness while about 19, 25,000 were estimated to have minor mental disorder. This study explores the relation between socio-cultural factors and mental illness prevalent among women, with particular reference to the women of Assam.

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Appendix I
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Appendix II
Research Questions and FGD topics

INTERVIEW SCHEDULE

ICMR Sponsored Project

Gender and Mental Health in Assam:
A Study on Magnitude, Cause and Impact of Mental Illness on Women

Department of Sociology
Tezpur University, Napaam, 784028, Assam

District Name	Code
Bongaigaon	1
Cachar	2
Darrang	3
Dibrugarh	4
Golaghat	5
Jorhat	6
Kamrup	7
Sibsagar	8
Sonitpur	9
Tinsukia	10

N.B:Particulars to be filled by the Field Assistant
(Serial nos. should be like 001, 012, 100 etc.)

District Code	Schedule Serial No.		

1	**Survey Date**	
2	**Name of the Hospital/ Organization/ Office**	
3	**Name of Field Assistant**	
4	**Name of the Respondent**	
5	**Contact no. of Respondent**	
6	**Name of Block**	
7	**Name of GaonPanchayat**	
8	**Name of Village**	

VILLAGE PROFILE

Date of visit ……
Name of the Field Assistant …….
Name of the Village……

GENERAL

1. **Name of the District……**
2. **Name of the Sub-division ……..…..**
3. **Name of the Circle ……..**
4. **Name of the Block ……..……..**
5. **Name of Panchayat……..**
6. **Name of the Village Head man/ woman ……**
7. **Village Boundary:**
    1. East……..
    2. West ……
    3. North ……..
    4. South……
8. **Distance from hub centre……**
9. **Population of the Village ……**
    1. Male……
    2. Female…….
10. **Number of Households …….**
11. **Number of Panchayat members**
    1. Male…….
    2. Female…….
12. **Police Outpost/Station**

……..……...

13. Post Office …….

14. Major Occupation of the Natives ……

15. Major Market Places …….

EDUCATION

16. Number of Anganwadi Schools……..

17. Number of Anganwadi workers (total no.) ……

18. Number of Primary Schools…….

19. Number of Secondary Schools ……..

20. Number of Colleges……

21. Number of Teachers ……

1. Male……
2. Female…….

22. Number of Students

1. Male……
2. Female…….

HEALTH

23. Number of Primary Health Centres……

24. Number of Dispensaries ……

25. Number of Community Health Cells…….

26. Number of Asha Workers……..

27. Number of Village Health Nutrition Day Centre (VHNDs) …….

28. Common Health Problems……..

29. Cases of Mental Illness (if any) …….

30. NGOs Working on Women/Health (if any) ……

SOCIO-CULTURAL INSTITUTIONS

31. Religious Institutions

1. Number of Temples……..
2. Number of Mosques……..
3. Number of Namghars……..
4. Number of Church……
5. Others…….

SOCIO-CULTURAL GROUPS

32. Number of Religious Groups…….

33. Number of .Caste Groups……

34. Number of Linguistic Groups……

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INTERVIEW SCHEDULE (Socio-cultural Aspect)

Sources: Households, village headmen, elderly people, SHGs, Faith Healers, socio-cultural forums, people related to religious institutions, priests, school teachers, anganwadi workers and so on.

Q.1. What is the impact of religion on people's lives? (as many as)

Shapes people's attitude and thought process

1. Regulates social life
2. Ensures moral conduct and ethical behavior
3. Preserves social norms
4. Blinds people from rational thinking
5. Accords unequal status
6. Cause of social disruption
7. Imposes illogical/ unjustified restrictions
8. Others

Comment on the relation of the above to mental health.

Q.2. What are the standard/ place of women in your religion?

1. Very High
2. High
3. Low
4. Very low
5. equal as men

Is it appropriate according to you?

1. Yes
2. No

Explain its relation to mental health.

Q.3. In your religion are women restricted from participating in the following?

1. Attending prayers in religious institutions (Temple/Mosque/Church/Namghar etc.)

1.Yes	☐
2.No	☐

2. Performing funeral rites

1.Yes ☐

2.No ☐

3. Participation of widows in auspicious occasions

1.Yes ☐

2.No ☐

4. Active role in religious rituals/ activities

1.Yes ☐

2.No ☐

5. Any other (specify)

……

……

……..

……..

(Please comment in relation to mental health)

Q.4. Degree of participation of women/men in religious rituals/ rites performed (active participation (Code 1)/ nominal participation (Code 2)/ ancillary participation (Code 3)/ exclusion from participation (Code 4)?

	Marriage rituals	**Birth rituals**	**Death rituals**	**Purification rituals**	**Puberty rituals**	**Other Auspicious rituals**
Men						
Women						

Elaborate comments in relation to self-esteem and mental health.

Q.5. In case there is no male child in a family, then is the female child allowed to perform funeral rites?

1. Yes
2. No

(Explain in relation to mental health)

Q.6. According to Custom/Culture what claim does a daughter have on her father's property?

1. She can inherit the property in the absence of a male child
2. Both male and female children have equal rights on parental property
3. Only son can inherit property
4. Other provisions/ practices

Q.7. Are there any rituals in your religion which are exclusively meant for women?

1. Yes
2. No
3. (Explain)

Q.8.What rules and regulations are defined by your religion to regulate moral behavior in men and women? Elaborate.

(Case studies)

Q.9.What punitive measures (common practices/ recent examples) may be taken for those transgressing the norms of morality? Elaborate.

(Case studies)

Q.10. Are any of the below mentioned practices followed in your community?

Widely practiced (Code 1), sometimes practiced (Code 2), Rarely practiced (Code 3), Never practiced (Code 4)

(Case studies preferred)

Practices	Men	Women	Socially acceptable	Not acceptable
Occult practices (witch-hunting, black magic etc.)				
Traditional healing				
Exorcism				
Any other				
None				

Elaborate your comment on the practices followed. Do you consider any of these practices as negative and harmful? (Draw relations to mental health)

Q.11. What are the measures taken in your community to control or curb such practices if followed? (as many as) (Case studies preferred)

1. Regulation by village council/ religious institutions
2. Complaint lodged with police
3. Ostracization
4. Persecution (Explain)
5. Others (specify)

Q.12. Is the culture of traditional healing prevalent in your community?

1. Yes
2. No

If yes, what are those practices? Are they endorsed by religious institutions or considered contravenous? (Comment in relation to mental health)

Q.13. Has there been any instance of witch-craft or any such practices among women in your community?

1. Yes
2. No

How does your religion/ religious institution view them/ redeem them or punish them?(Case studies)

Q.14. What according to you are the causes of mental illness in women?

1. Genetic
2. Mental stress
3. Over work
4. Disobeying her husband/elders
5. Sexual exploitation
6. Physical illness
7. Curse
8. Others

Do you think the reasons are different from those of men?

1. Yes
2. No

If yes, why do you think so?

Q.15. Are there practices in your religion that can claim to heal mental illness?

1. Yes
2. No

Explain. (Case studies preferred)

Q.16. How does mental illness affect a family?

	Isolated	**Prospect of marriage** **- No prospect (Code1)** **- Limited/Reduced prospect (Code 2)** **- No change in prospect (Code 3)**	**Low social status** **-Yes (Code 1)** **-No(Code 2)** **- Same as before (Code 3)**	**Participation in social activities (religious/ cultural)** **-No participation (Code 1)** **- Reduced/ Limited (Code 2)** **-Same as before (Code 3)**	**Employment prospects** **-No prospect (Code 1)** **- Reduced/ Limited (Code 2)** **-Same as before (Code 3)**	**Others** **(Code 4)**
Patient						
Family						

FGD/ Key informant technique to elicit inputs on the following in relation to mental health: (5 FGDs)

1. FGD with panchayat members
2. FGD with SHGs/ any women's organized group
3. FGD with Anganwadi/ Asha workers
4. FGD with school teachers
5. FGD with group of house wives
6. FGD with group of men
7. FGD with cultural forum/club members

Key informants (3-5 informants)

1. Religious leaders/ priests/ faith healers
2. Village head man/ elderly/ reputed people in the village
3. Youth leaders

Themes:

1. Your general opinion on the social status of women in society. Does it affect their self-esteem, their sense of security, their role and responsibility in social matters, does these reflect upon the mental health/ state of women?
2. Are they considered burden/ assets/ on the society? Elaborate the same with regard to general well-being of women.
3. Should women be made integral part in decision making process? What are the customary norms and practices? Does this decision making power or the absence of it tells upon the mental health (feeling of inferiority, depression, anxiety, frustration, suppressed aspirations, exploitation etc.)
4. Are voices of women included in panchayat and community decisions? Do you think they are capable of making rational decision? Do you think they are capable of contributing to the development of community? What risks/threats do politically active women face? (instances/cases)
5. Role of women in sustaining patriarchy and endorse age old traditions without any questioning?
6. Status of widow/ childless/ barren/ women not having a male child/ unmarried women in society? (Are they ostracized? How it may affect the mental health?)
7. Are working women considered dishonour in family?
8. Opinion about education

9. Women need to study to tutor their children
10. Aspirations remain unfulfilled
11. What are the mental illnesses common in women in your society/ community?
12. Is it related to alcoholism and immortality among women
13. Poverty and hardships of life
14. Sexual abuse/ exploitation/ other sorts of violence
15. Any rejuvenating activity for women towards positive mental health?
16. Opinions of women how they perceive about own self, their self-esteem and status in society.
17. Opinions related to puberty rituals (Is it a polluting factor?)

(ALL THE THEMES NEED TO BE DISCUSSED IN THE CONTEXT OF OVER ALL MENTAL HEALTH/ MENTAL STATUS OF WOMEN)

INTERVIEW SCHEDULE (Economic Aspect)

General Research Questions Household Survey:

Q.1. who are the earning members of the household?

1. Father
2. Mother
3. Husband
4. Wife
5. Both husband and wife
6. Others (Specify)

Q.2. what is the total income (per month) of the household?

1. Up to 1000
2. Between 1001 to 5000
3. Between 5001 to 9000
4. Between 9001 to 13000
5. Between 13001 to 25000
6. 25000 and above

Q.3. Nature of the work.

1. Agriculture and Allied
2. Daily wage earner
3. Salaried Service(regular)
4. Salaried but casual
5. Unemployed
6. Others (Specify)

Q.4. What are the difficulties women experiences while running the household within the limited monthly income?

1. Difficulty in providing at least two square meals for the family.
2. Difficulty in providing education for the children.
3. Difficulty in covering health related expenses.
4. All of the above

How are the above related to mental health? How does it make you feel? Does it push you to the brink of desperation? (Helpless/ unsuccessful/ fearful/ insecure)

Q.5. Is monthly saving possible within the monthly income?

1. Yes
2. No

If yes, what percentage?

Monthly income	*Estimation of expenditure in % (approx.)*	*Estimation of saving in % (approx.)*

Q.6. How is the expenditure of the house prioritized? (Prioritize in terms of number)

1. Food
2. Education
3. Clothing
4. House maintenance/ construction,

5. Medical facilities
6. Occupational investment
7. Amenities (mobile, cable charge, fuel etc., asset development like bike, car, cattle etc., savings)

Q.7. Do your personal needs gain priority?

1. Yes
2. No

If yes, how does that make you feel?

1. *General sense of satisfaction*
2. *Acknowledgement as an important entity in family*
3. *Sense of being loved and cared for*
4. *Unnecessary as my priorities are not important*
5. *A burden on the household income*

If no, how does that make you feel?

1. *Neglected and unimportant*
2. *Personal needs not acknowledged or recognized*
3. *Liability for family members*
4. *Dejected and depressed*
5. *No issues/ problem as I value other members' needs over mine*

Q.8. Does alcoholism affect your family's income/ general wellbeing?

1. Yes

20-30 %	30-40%	More than 50%

2. No

Note: *How does alcoholism affect the well-being and mental state of you, your children and family as a whole?*

Q.9. Do you face anxiety managing your household expenses?

1. Yes
2. No
3. At times

Q.10. Do you feel guilty in not being able to provide for the needs of your family?

1. Yes
2. No
3. At times

Q.11. Does economic dependence frustrates you?

1. Yes
2. No
3. At times

Q.12. Do you feel that if you had worked, your family would have been more solvent?

1. Yes
2. No
3. At times

Q.13. Do you feel that your husband and children would have respected you more if you were working and earning money for the family?

1. Yes
2. No
3. At times

Q.14. What ailments do you suffer from?

Q.15. How many times you/your husband/children visit the PHCs and hospitals?

	Husband	Children	You	Other members
Monthly				
Quarterly				
Half yearly				
Yearly				
Only during emergency				

Q.16. Are you aware that anemia, calcium deficiency, malnutrition are common among young and middle -aged women?

1. Yes
2. No

Q.17. Do you take supplements to overcome this deficiency? (If 'no' please specify)

1. Yes
2. No
3. Sometimes

Q.18. Is the family headed by a woman?

1. Yes
2. No

Q.19. Is anybody in your family a working woman?

1. Yes
2. No

Research Questions Specifically for Working Women:

Q.1. Does managing work and household create stress? (If yes, please explain in relation to over all mental health)

1. Yes
2. No

Q.2. Tell us something about the nature of your work.

1. Agriculture and Allied
2. Daily wage earner
3. Salaried Service(regular)
4. Salaried but casual
5. Unemployed
6. Others (Specify)

Note: How does that make you feel? Please explain in relation to over all mental health.

Q.3. Are you happy/ satisfied by the work that you do? (Please explain in relation to over all mental health)

1. Yes
2. No
3. Can't say

Q.4. Do you get adequate respect in the workplace?

1. Yes
2. No

How does that make you feel? (Please explain in relation to over all mental health)

Q.5. Do you feel guilty that because of you being a working woman your husband and children are neglected? (Please explain in relation to over all mental health)

1. Yes
2. No
3. At times

Q.6. What physical health hazards are you exposed to in your workplace?

1. Pollution
2. Unhygienic working condition
3. Overloaded work burden
4. Others (specify)
5. None

Does that affect you mentally as well? (Please explain in relation to over all mental health)

Q.7. Do you have a say in the manner in which your income is utilized in your house? How do you feel about it? (Please explain in relation to over all mental health)

1. Yes
2. No

Research Questions Specifically for Female-headed Households:

Q.1. What has led to you being head of the family/ household?

1. Husband's death
2. Alcoholic husband
3. Absence of male member (brother/ father)
4. Unmarried status
5. Any other reason (please specify)

Q.2. How do you feel about you being the head of the household? (Please explain in relation to over all mental health)

1. Empowered
2. Insecure
3. Burdened
4. Others

Q.3. What difficulties do you face as the head of the family? (Please explain in relation to over all mental health)

1. Economic crisis

2. Social discrimination
3. Security issues
4. Any other (please specify)

Q.4. Highlight the experiences you have undergone/ still undergoing as a single women –

1. Have your dreams and aspirations about a family fulfilled?
2. How is the attitude of family members / relatives/ neighbors / society towards you?
3. Care/ attitude of children towards her;
4. Fears, insecurities and frustrations she experiences with regard to her present and future;

Q.5. How does she look back at her past? Does she feel better in her present situation or she felt better in the past?

Q.6. What property/ assets have your husband left for you (in case of widow) and what have you inherited (from parents)?

1. House
2. Land
3. Cash
4. Insurance policies etc.
5. Any other asset

Q.7. Have you been able to maintain/ retain what you have acquired or inherited?(Explain)

1. Yes
2. No

Q.8. What difficulties do you face in maintaining/ retaining the property?

1. Distress selling owing to poverty;

2. Threats from relatives;

3. Other forms of threat beyond the group of relatives/ kith and kin.

(How do you feel about it?)

Research Questions Identified Specifically for Critical Patients (collect answers in a story telling mode):

Q.1 What was her education?

1. Never been to school
2. Under-matriculation
3. Secondary
4. higher secondary
5. others

Q.2. What are my aspirations towards career? (Please explain in relation to over all mental health)

1. I always wanted to work
2. I was/am a working woman
3. I am/ was satisfied with the kind of work I am/ was doing?
4. Any other aspiration (Please specify)

Q.3. If she didn't work, how did her dependence make her feel? (Please explain in relation to over all mental health)

1. Comfortable
2. A burden/ liability on others
3. Low self-esteem
4. Neglectful attitude of others
5. Other feelings

Q.4. If she was working, what were her experiences at work place? (Please explain in relation to over all mental health)

1. I received equal treatment as others (male counterparts/ other cultural factors)
2. It was a satisfactory and congenial atmosphere
3. Faced discrimination
4. Low wage
5. Exploitation
6. Sexual abuse

7. Others

Q.5. How important is money in her life? (Please explain in relation to over all mental health)

1. Very important
2. Not very important
3. Not important at all

Q.6. What problems did she face because of her economic conditions? (Please explain in relation to over all mental health)

1. Incomplete/ no education
2. Early marriage
3. Strenuous jobs
4. Health issues
5. Social discrimination/ exploitation
6. Others

Q.7. What is her opinion towards her husband's status as an earning member? (Please explain in relation to over all mental health)

1. He's the earning member; therefore, the head of the family
2. He's a man; so, he's the decision maker
3. He's earns money; therefore, can't be questioned on how he spends the money
4. Even though he earns, the wife should have equal say in the household expenditure
5. Husband and wife should take mutual decisions
6. Because the wife doesn't earn she has a low status is accorded to her in the house
7. Any other opinion.

Q.8. Experiences in natal v/s in- law's house? (Please explain in relation to self esteem/self perception)

	Husband's house	Her natal house
Freedom		

Respect/ Love/ care		
Decision making power		
Burden of domestic work		
Working status		
Social status		
Any other (Please comment)		

Q.9. Do you get any physical health treatment? (Please explain in relation to over all mental health)

Regular	sometimes	Only when required	never

Q.10. What do you think about your mental health?

1. Debilitating
2. Able to function normally in spite of her condition
3. Unjustified social ostracization/ isolation?
4. A shameful condition/ disorder
5. Others

Q.11. What is her opinion towards poverty and its consequences?(Elaborate in relation to mental health)

1. Disturbs mental health
2. Low social status
3. Disrupts family well-being
4. Unfulfilled aspirations/ dreams/ desires etc.
5. Exposure to social threats and other risks
6. Others

Q.12. Does she feel guilty about the expenditure spent on her mental health? (Elaborate in relation to mental health)

1. Yes
2. No
3. At times.

ECONOMIC IMPACT OF MENTAL ILLNESS

Q.1. Burden on household income

No. of employed persons	Cumulative monthly income	No. of patients	Total monthly cost on treatment

Q.2. Cost of care

No. of care givers	M/F	Working/ Non-working/ working part time/ Formerly employed	Monthly Income	Remarks
1)				
2)				
3)				

Q.3. Cost of treatment

Monthly Expenditure	Consultation	Test/ Investigation/ Diagnosis	Travel Cost	Medicines	Hospitalization/ Rehabilitation

Q.4. Do you think mental illness treatment is more costly than other forms of general illness?

1. Yes
2. No

If yes, it is because of

1. *Inaccessibility (health care institutions located far away)*
2. *Expensive / unavailability of medicines*
3. *Life-long treatment*
4. Others (please elaborate

Q.5.Has mental illness led to other forms of physical illnesses?

1. Yes
2. No

If yes,

1. *In case of patients (either induced by medicine or stress related to illness)*

Disease	*Treatment cost (monthly)*
Hypertension	
Diabetes	
Arthritis	
Others	

2. *In case of family members*

Disease	*Treatment cost (monthly)*
Hypertension	
Diabetes	
Arthritis	
Others	

Q.6. Has mental illness of a family member affected the income status of any other member (s)?

Affected member(s)	Nature of employment	Former income (monthly)	Present income (monthly)	Remarks
1.				
2.				
3.				

Q.7. Reduced income potential of family

Number of earning members	Average income per individual (monthly)	Number of mentally ill patients Age (15 – 59)	Reduced income
1.			
2.			
3.			

Q.8. Reduction in family income (Monthly)

Number of mentally ill patients	Employed earlier	Income (monthly)	Present employment status(unemployed/part time/sporadic/active as before)	Present income
1.				
2.				
3.				

** Case studies on both positive and negative aspects

FGD/ Key informant technique to elicit inputs on the following in relation to mental health: (3 FGDs)

1. FGD with women of organized sector (Local factory/ industry workers/ tea garden labourers)

2. FGD with women of unorganized Sector (Construction workers/ weavers/ domestic helps/ market women vendors)

3. FGD with SHG

Key informants (3-5 informants)

1. Religious leaders/ priests/ faith healers
2. Village head man/ elderly/ reputed people in the village
3. Youth leaders

FGD Themes:

1. General opinion about the importance of women economic independence.

2. How economic dependence affects women? (decision making role, suppression, oppression and related to mental health).

3. Draw out cases of people whom they know where poverty/ alcoholism have caused insanity in women.

4. Impact of psychiatric patient on the economy of the family.

5. How the presence of patient has disrupted family's economy? (When the patient is a male and when the patient is a female).

INTERVIEW SCHEDULE (Awareness)

Q.1. Mental illness is an illness of:

1. Thought & Behaviour	1.Paranoia (unreasonable fear)	
	2.Over dependence	
	3.Aggressiveness	
	4.Hearing voices	
	5.Loss of motivation	
2. Perception	1.Fluctuation in intensity of thoughts	
	2. Sensory distortions (Unreal perception of shapes, sounds etc.)	
	3.Hallucination	
	4.Illusion	
	5.Delusion (extraordinary conviction about a false/imaginary idea or belief)	
3. Emotion	1. Hyper-active	
	2. Hypo-active	
	3. Sadness	
	4. Aggression	
4. Cognition	1. Frequent mood swing	
	2. Bipolar (Extreme euphoria/ extreme sadness)	
	3. Forgetfulness	
	4. Delirium	
5.Personality	1. Eccentric	
	2. Antisocial	
	3. Narcissistic (extremely self centred)	
	4. Obsessive compulsion	

	5. Dependence	
	6. Insecurity/inferiority complex	

Q.2. Mental illness is caused by-

1. Genetic/Hereditary
2. Infection
3. Accident/ head injury
4. Curse/ possession/ evil spirits/ witch craft/ bad karma
5. Side-effects of medicines/ treatment/alcohol/cannabis
6. Stress/violence/disaster
7. Disorder of brain
8. Others

Q.3. Mental illness can affect-

1. Everybody
2. Only family members of mentally ill persons
3. Persons having physical ailments
4. Others

Q.4. Symptoms of good mental health include (as many as)-

1. Proper sleep
2. Positive outlook and lively spirit
3. High self- esteem
4. Ability to concentrate
5. Sociable nature
6. Strength to face hurdles
7. Competitive attitude
8. Inferiority complex
9. Jealously and selfishness

Q.5. There is no hope for mentally ill patients

1. Yes, they will never recover
2. Patients with mild symptoms recover fully

3. Temporarily can be controlled
4. Proper treatment and routine follow-up necessary for improvement
5. Depends on the severity of illness
6. Rituals performance may be helpful
7. Some people may need rehabilitation

Q.6. Mental health treatment is expensive

1. Yes
2. No
3. Affordable

Q.7. The children of either or both mentally ill patients would inevitably acquire mental illness. Cite Reasons.

1. True
2. False

Q.8. Are all mentally ill patients violent?

1. Yes, all are
2. No, some are violent
3. If handled well, none is violent
4. Others

Q.9. Has any mental awareness camp organized in your neighbourhood? Have you heard of any?

Q.10. Have you heard of any govt. programme on mental health or the Mental Health Bill?

Q.11. Mental illness affects women more.

1. Yes
2. No

Q.12. Mental illness should be always treated -

1. Mostly can be treated at home with regular treatment and they can have normal life.
2. Some may need lifelong hospitalization.
3. Some may need rehabilitation facility/day care/institutional care
4. Some may need repeated hospitalization

Q.13. Mental illness can develop along with

1. Chronic health conditions
2. Diabetes
3. Hypertension
4. Debilitation due to pain, arthritis etc.

Q.14. Are you aware that mentally ill people can avail free legal services?(National Legal Services Scheme)

1. Yes
2. No

Q.15. Are you aware of the govt. schemes for the disables and the mentally ill people?

1. Yes
2. No

If yes, explain.

INTERVIEW SCHEDULE (Attitude)

Q.1. Mentally ill patients should be isolated/ tied up? Cite why?

1. Yes
2. No

Q.2. The presence of a mentally ill person in a family is a matter of shame and should therefore be kept under wraps.

1. Yes
2. No

Q.3. Locating mental health facilities in a residential area downgrade the neighbourhood.

1. Yes
2. No

Q.4. It is frightening to think of people with mental problems living in residential neighbourhoods?

1. Yes
2. No

Q.5. I would not want to live next door to someone who has been mentally ill.

1. Yes
2. No

Q.6. It would be foolish to marry in a family where the woman (mother/sister/ girl herself) has suffered from mental illness, even though she seems fully recovered.

1. Yes
2. No

Q.7. Anyone with a history of mental problems should be excluded from taking public office.

1. Yes
2. No

Q.8. People who had mental illness should not be given any responsibility.

1. Yes
2. No

Q.9. People with mental illness are a burden on society

1. True
2. False

Q.10. As soon as a person shows signs of mental disturbance, he should be hospitalized.

1. Yes
2. No

Q.11. We have a responsibility to provide the best possible care for people with mental illness.

1. Yes
2. No

Q.12. Virtually anyone can become mentally ill.

1. True
2. False

Q.13. Increased spending on mental health services is a waste of money.

1. True
2. False

Q.14. People with mental illness don't deserve our sympathy.

1. True
2. False

Q.15. We need to adopt a far more tolerant attitude toward people with mental illness in our society.

1. True
2. False

Q.16. People with mental illness have for too long been the subject of ridicule.

1. True
2. False

Q.17. As far as possible, mental health services should be provided through community based facilities.

1. True
2. False

Q.18. People with mental illness are far less of a danger than most people suppose.

1. True
2. False

Q.19. Less emphasis should be placed on protecting the public from people with mental illness.

1. True
2. False

Q.20. The best therapy for many people with mental illness is to be part of a normal community.

1. True
2. False

Q.21. Residents have nothing to fear from people coming into their neighborhood to obtain mental health services.

1. True
2. False

Q.22. People with mental health problems should have the same rights to a job as anyone else.

1. True
2. False

Q.23. Most women who were once patients in a mental hospital can be trusted as babysitters.

1. Yes, if she is fully cured
2. No, not at all

Q.24. Mental illness is an illness like any other physical illness.

1. True
2. False

Q.25. No-one has the right to exclude people with mental illness from their neighbourhood.

1. True
2. False

Q.26. Mental hospitals are an outdated means of treating people with mental illness.

1. True
2. False

Q.27. There are sufficient existing services for people with mental illness.

1. True
2. False

Q.28. One of the main causes of mental illness is a lack of self-discipline and will-power.

1. True
2. False

Q.29. Do you think that people with mental illness experience stigma and discrimination?

1. Yes
2. No

Q.30. If you felt that you had a mental health problem, how likely would you be to go to your GP for help?

1. Yes
2. No

Q.31. Mentally ill persons can be treated at

1. Govt. hospital (District hospital/Medical College/ Mental hospital etc.)
2. Govt. health centers
3. Private hospital
4. Jails
5. Home

(Source: Attitudes to Mental Illness TNS BMRB 2013)

Appendix III

Percentage of Women Identified with Mental Illness

(Village wise data)

BONGAIGAON DISTRICT

Village	Chokapara		
Total Population	Male	Female	
	567	563	
Total no. of Probable Cases	Male	Female	
	16	10	
Total no. of Common Cases	Male	Female	
	12	6	
Avg. No. of Probable Symptoms	4		
Most Common Symptoms	2,9,10,14		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	1:1	Male	Female
		20-60	20-60
Percentage of Women Afflicted	0.88% of the total female population		

Village	Majgaon		
Total Population	Male	Female	
	412	415	
Total no. of Probable Cases	Male	Female	
	18	12	
Total no. of Common Cases	Male	Female	
	13	8	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	5,6,8,10,11		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	6:5	Male	Female
		20-60	20-60
Percentage of Women Afflicted	1.20% of the total female population		

Village	Ghandal		
Total Population	Male	Female	
	414	435	
Total no. of Probable Cases	Male	Female	
	16	9	
Total no. of Common Cases	Male	Female	
	12	5	
Avg. No. of Probable Symptoms	4		
Most Common Symptoms	2,3,11,14		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	1:1	Male	Female
		20-60	20-60
Percentage of Women Afflicted	1.14% of the total female population		

Village	Siponchila		
Total Population	Male	Female	
	358	357	
Total no. of Probable Cases	Male	Female	
	18	10	
Total no. of Common Cases	Male	Female	
	15	7	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	3,8,9,10,14		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	1:1	Male	Female
		20-60	20-60
Percentage of Women Afflicted	1.12% of the total female population		

Village	Jakuapara		
Total Population	Male	Female	
	480	444	
Total no. of Probable Cases	Male	Female	
	20	7	
Total no. of Common Cases	Male	Female	
	17	3	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	2,4,8,9,11		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	4:5	Male	Female
		20-60	20-60
Percentage of Women Afflicted	1.12% of the total female population		

Village	Gunialguri		
Total Population	Male	Female	
	313	319	
Total no. of Probable Cases	Male	Female	
	18	12	
Total no. of Common Cases	Male	Female	
	13	8	
Avg. No. of Probable Symptoms	4		
Most Common Symptoms	5,6,11,14		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	6:5	Male	Female
		20-60	20-60
Percentage of Women Afflicted	1.56% of the total female population		

Village	Mojairmukh		
Total Population	Male	Female	
	342	315	
Total no. of Probable Cases	Male	Female	
	19	10	
Total no. of Common Cases	Male	Female	
	14	7	
Avg. No. of Probable Symptoms	4		
Most Common Symptoms	2,3,8,14		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	3:2	Male	Female
		20-60	20-60
Percentage of Women Afflicted	1.26% of the total female population		

Village	Pakhiriguri		
Total Population	Male	Female	
	379	415	
Total no. of Probable Cases	Male	Female	
	18	12	
Total no. of Common Cases	Male	Female	
	15	8	
Avg. No. of Probable Symptoms	4		
Most Common Symptoms	4,8,9,14		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	4:5	Male	Female
		20-60	20-60
Percentage of Women Afflicted	1.20% of the total female population		

Village	Lengtisingapara		
Total Population	Male	Female	
	197	199	
Total no. of Probable Cases	Male	Female	
	10	8	
Total no. of Common Cases	Male	Female	
	7	6	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	5,6,8,9,11		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	4:3	Male	Female
		20-60	20-60
Percentage of Women Afflicted	1.50% of the total female population		

Village	Narikola		
Total Population	Male	Female	
	296	332	
Total no. of Probable Cases	Male	Female	
	13	10	
Total no. of Common Cases	Male	Female	
	8	7	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	2,3,4,8,9		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	3:2	Male	Female
		20-60	20-60
Percentage of Women Afflicted	1.20% of the total female population		

CACHAR DISTRICT

Village	Saidpur		
Total Population	Male	Female	
	1662	1685	
Total no. of Probable Cases	Male	Female	
	5	4	
Total no. of Common Cases	Male	Female	
	4	4	
Avg. No. of Probable Symptoms	7		
Most Common Symptoms	1,6,8		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	2:1	Male	Female
		30-60	20-58
Percentage of Women Afflicted	0.059% of the total female population		

Village	Chandrapur I		
Total Population	Male	Female	
	1946	1861	
Total no. of Probable Cases	Male	Female	
	3	5	
Total no. of Common Cases	Male	Female	
	1	2	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	3,6,1,8		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	3:4	Male	Female
		20-60	20-65
Percentage of Women Afflicted	0.215% of the total female population		

Village	Ambikapur		
Total Population	Male	Female	
	7309	6974	
Total no. of Probable Cases	Male	Female	
	4	4	
Total no. of Common Cases	Male	Female	
	4	3	
Avg. No. of Probable Symptoms	6		
Most Common Symptoms	1,3,6		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	1:2	Male	Female
		20-60	20-50
Percentage of Women Afflicted	0.029% of the total female population		

Village	Daspara		
Total Population	Male	Female	
	Census 2011 data not available	Census 2011 data not available	
Total no. of Probable Cases	Male	Female	
	4	3	
Total no. of Common Cases	Male	Female	
	3	3	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	1,6,3		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	3:4	Male	Female
		20-60	20-50
Percentage of Women Afflicted	Couldn't be calculated		

Village	Chottojalenga		
Total Population	Male	Female	
	138	126	
Total no. of Probable Cases	Male	Female	
	4	5	
Total no. of Common Cases	Male	Female	
	3	4	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	1,6,8,3		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	1:1	Male	Female
Percentage of Women Afflicted	1.587% of the total female population		

Village	Rosekandi		
Total Population	Male	Female	
	1111	1130	
Total no. of Probable Cases	Male	Female	
	5	4	
Total no. of Common Cases	Male	Female	
	4	4	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	1,6.3		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	2:1	Male	Female
		20-60	20-50
Percentage of Women Afflicted	0.088% of the total female population		

Village	Silcoorie		
Total Population	Male	Female	
	10087	9550	
Total no. of Probable Cases	Male	Female	
	5	5	
Total no. of Common Cases	Male	Female	
	5	4	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	1,7,3		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	1:2	Male	Female
		20-60	20-50
Percentage of Women Afflicted	0.021% of the total female population		

Village	Duarbond		
Total Population	Male	Female	
	1650	1535	
Total no. of Probable Cases	Male	Female	
	4	4	
Total no. of Common Cases	Male	Female	
	3	2	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	1,3,6		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	2:3	Male	Female
		20-60	20-50
Percentage of Women Afflicted	0.195% of the total female population		

Village	Bariknagar		
Total Population	Male	Female	
	591	618	
Total no. of Probable Cases	Male	Female	
	5	4	
Total no. of Common Cases	Male	Female	
	4	2	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	1,8,6		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	2:3	Male	Female
		20-60	20-50
Percentage of Women Afflicted	0.485% of the total female population		

Village	Loharbond		
Total Population	Male	Female	
	79	75	
Total no. of Probable Cases	Male	Female	
	4	3	
Total no. of Common Cases	Male	Female	
	3	2	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	1,8,6		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	1:1	Male	Female
		20-60	20-50
Percentage of Women Afflicted	2.667% of the total female population		

DARRANG DISTRICT

Village	DHULA		
Total Population	Male	Female	
	3006	2962	
Total no. of Probable Cases	Male	Female	
	5	5	
Total no. of Common Cases	Male	Female	
	1	1	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	Who suffers from fits or loss of consciousness?		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	1:1	Male	Female
		35	45
Percentage of Women Afflicted	0.169% of the total female population		

Village	BANDIA		
Total Population	Male	Female	
	626	593	
Total no. of Probable Cases	Male	Female	
	5	5	
Total no. of Common Cases	Male	Female	
	5	1	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	Who suffers from fits or loss of consciousness?		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	1:5	Male	Female
		30	40
Percentage of Women Afflicted	0.843% of the total female population		

Village	ABHAY PUKHURI		
Total Population	Male	Female	
	297	302	
Total no. of Probable Cases	Male	Female	
	5	5	
Total no. of Common Cases	Male	Female	
	5	5	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	Who suffers from fits or loss of consciousness?		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	1:1	Male	Female
		20	44
Percentage of Women Afflicted	0.331% of the total female population		

Village	BALABARI		
Total Population	Male	Female	
	1179	1180	
Total no. of Probable Cases	Male	Female	
	5	5	
Total no. of Common Cases	Male	Female	
	5	5	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	Who suffers from fits or loss of consciousness?		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	1:1	Male	Female
		40	50
Percentage of Women Afflicted	0.085% of the total female population		

Village	CHAULKHUWA		
Total Population	Male	Female	
	1265	1182	
Total no. of Probable Cases	Male	Female	
	5	5	
Total no. of Common Cases	Male	Female	
	5	5	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	Who suffers from fits or loss of consciousness?		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	1:1	Male	Female
		35	45
Percentage of Women Afflicted	0.085% of the total female population		

Village	DAHI		
Total Population	Male	Female	
	987	930	
Total no. of Probable Cases	Male	Female	
	5	5	
Total no. of Common Cases	Male	Female	
	5	1	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	Who suffers from fits or loss of consciousness?		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	1:5	Male	Female
		20	45
Percentage of Women Afflicted	0.538% of the total female population		

Village	UPAHUPARA		
Total Population	Male	Female	
	298	289	
Total no. of Probable Cases	Male	Female	
	5	5	
Total no. of Common Cases	Male	Female	
	1	1	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	Who suffers from fits or loss of consciousness?		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	1:1	Male	Female
		35	45
Percentage of Women Afflicted	1.730% of the total female population		

Village	CHAPAI		
Total Population	Male	Female	
	428	396	
Total no. of Probable Cases	Male	Female	
	5	5	
Total no. of Common Cases	Male	Female	
	1	1	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	Who suffers from fits or loss of consciousness?		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	1:1	Male	Female
		30	50
Percentage of Women Afflicted	1.263% of the total female population		

Village	RAMHARI		
Total Population	Male	Female	
	587	298	
Total no. of Probable Cases	Male	Female	
	6	4	
Total no. of Common Cases	Male	Female	
	6	1	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	Who suffers from fits or loss of consciousness?		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	1:4	Male	Female
		40	40
Percentage of Women Afflicted	1.342% of the total female population		

Village	NAGARBAHI		
Total Population	Male	Female	
	868	848	
Total no. of Probable Cases	Male	Female	
	5	5	
Total no. of Common Cases	Male	Female	
	1	1	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	Who suffers from fits or loss of consciousness?		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	1:1	Male	Female
		40	45
Percentage of Women Afflicted	0.590% of the total female population		

DIBRUGARH DISTRICT

Village	BOKPARA		
Total Population	Male	Female	
	721	746	
Total no. of Probable Cases	Male	Female	
	2	5	
Total no. of Common Cases	Male	Female	
	0	1	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	2,9		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	2:5	Male	Female
		20-60	20-60
Percentage of Women Afflicted	0.670% of the total female population		

Village	JAMIRA KAPOU GAON		
Total Population	Male	Female	
	567	563	
Total no. of Probable Cases	Male	Female	
	2	5	
Total no. of Common Cases	Male	Female	
	1	1	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	2,9		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	3:5	Male	Female
		20-60	20-60
Percentage of Women Afflicted	0.888% of the total female population		

Village	TEKALASIRING		
Total Population	Male	Female	
	836	678	
Total no. of Probable Cases	Male	Female	
	2	5	
Total no. of Common Cases	Male	Female	
	1	1	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	2,9,14		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	2:5	Male	Female
		20-60	20-60
Percentage of Women Afflicted	0.737% of the total female population		

Village	LEZAI		
Total Population	Male	Female	
	836	678	
Total no. of Probable Cases	Male	Female	
	2	5	
Total no. of Common Cases	Male	Female	
	1	1	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	2,9,14		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	2:5	Male	Female
		20-60	20-60
Percentage of Women Afflicted	0.737% of the total female population		

Village	KHOWANG KAWOIMARIGAON		
Total Population	Male	Female	
	666	503	
Total no. of Probable Cases	Male	Female	
	2	5	
Total no. of Common Cases	Male	Female	
	1	1	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	Who suffers from fits or loss of consciousness?		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	2:5	Male	Female
		20-60	20-60
Percentage of Women Afflicted	0.994% of the total female population		

Village	BUKAKHOLA		
Total Population	Male	Female	
	240	260	
Total no. of Probable Cases	Male	Female	
	0	5	
Total no. of Common Cases	Male	Female	
	0	1	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	Who suffers from fits or loss of consciousness?		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	0:5	Male	Female
		30-45	22-45
Percentage of Women Afflicted	1.923% of the total female population		

Village	KUARGAON		
Total Population	Male	Female	
	836	678	
Total no. of Probable Cases	Male	Female	
	2	5	
Total no. of Common Cases	Male	Female	
	1	1	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	Who suffers from fits or loss of consciousness?		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	2:5	Male	Female
		20-60	20-60
Percentage of Women Afflicted	0.737% of the total female population		

Village	DOLONIKUR		
Total Population	Male	Female	
	361	305	
Total no. of Probable Cases	Male	Female	
	1	5	
Total no. of Common Cases	Male	Female	
	1	1	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	Who suffers from fits or loss of consciousness?		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	1:5	Male	Female
		20-60	20-60
Percentage of Women Afflicted	1.639% of the total female population		

GOLAGHAT DISTRIC

Village	TeliaGaon		
Total Population 954	Male	Female	
	488	466	
Total no. of Probable Cases 36	Male	Female	
	14	22	
Total no. of Common Cases 9	Male	Female	
	4	5	
Avg. No. of Probable Symptoms	6		
Most Common Symptoms	2,4		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	11:18	Male	Female
		20-60	20-60
Percentage of Women Afflicted	3.862% of the total female population		

Village	Panikora		
Total Population 1066	Male	Female	
	542	524	
Total no. of Probable Cases 21	Male	Female	
	5	16	
Total no. of Common Cases 7	Male	Female	
	2	5	
Avg. No. of Probable Symptoms	3		
Most Common Symptoms	2,4,9		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	1:3	Male	Female
		20-60	20-60
Percentage of Women Afflicted	2.290% of the total female population		

Village	2 no. Kaibatra		
Total Population 903	Male	Female	
	466	437	
Total no. of Probable Cases 37	Male	Female	
	15	22	
Total no. of Common Case 10	Male	Female	
	5	5	
Avg. No. of Probable Symptoms	6		
Most Common Symptoms	2,8		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	11:18	Male	Female
		20-60	20-60
Percentage of Women Afflicted	4.119% of the total female population		

Village	Sesamukh		
Total Population 403	Male	Female	
	216	201	
Total no. of Probable Cases 36	Male	Female	
	16	20	
Total no. of Common Cases	Male	Female	
	3	6	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	2,4,9		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	14:15	Male	Female
		20-60	20-60
Percentage of Women Afflicted	7.463% of the total female population		

Village	Patkotia		
Total Population 1583	Male	Female	
	784	799	
Total no. of Probable Cases 35	Male	Female	
	14	17	
Total no. of Common Cases 12	Male	Female	
	3	7	
Avg. No. of Probable Symptoms	7		
Most Common Symptoms	2,3,4,8		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	12:11	Male	Female
		20-60	20-60
Percentage of Women Afflicted	1.377% of the total female population		

Village	1no. Tengahola		
Total Population 954	Male	Female	
	488	466	
Total no. of Probable Cases 36	Male	Female	
	16	14	
Total no. of Common Cases 12	Male	Female	
	5	7	
Avg. No. of Probable Symptoms	6		
Most Common Symptoms	2,4		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	3:2	Male	Female
		20-60	20-60
Percentage of Women Afflicted	1.717% of the total female population		

Village	Moran Gaon		
Total Population 1468	Male	Female	
	741	727	
Total no. of Probable Cases 38	Male	Female	
	15	23	
Total no. of Common Cases 9	Male	Female	
	4	6	
Avg. No. of Probable Symptoms	6		
Most Common Symptoms	1,2,9		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	2:3	Male	Female
		20-60	20-60
Percentage of Women Afflicted	2.476% of the total female population		

Village	2 no. Tengahola		
Total Population	Male	Female	
831	420	411	
Total no. of Probable Cases	Male	Female	
36	16	20	
Total no. of Common Cases	Male	Female	
12	5	5	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	2,9		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	3:4	Male	Female
		20-60	20-60
Percentage of Women Afflicted	3.893% of the total female population		

Village	2 no. Gondhokoroiguri		
Total Population	Male	Female	
1828	909	919	
Total no. of Probable Cases	Male	Female	
32	14	18	
Total no. of Common Cases	Male	Female	
10	4	6	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	2,8,9		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	11:13	Male	Female
		20-60	20-60
Percentage of Women Afflicted	1.414% of the total female population		

Village	Latajuri		
Total Population	Male	Female	
899	454	445	
Total no. of Probable Cases	Male	Female	
35	14	21	
Total no. of Common Cases	Male	Female	
10	3	7	
Avg. No. of Probable Symptoms	7		
Most Common Symptoms	2,3,4,9,14		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	12:15	Male	Female
		20-60	20-60
Percentage of Women Afflicted	3.371% of the total female population		

JORHAT DISTRICT

Village	DihaGajpuria		
Total Population	Male	Female	
	775	767	
Total no. of Probable Cases	Male	Female	
	4	5	
Total no. of Common Cases	Male	Female	
	2	3	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	Who is mad, talk's nonsense and acts in a strange manner?		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	1:1	Male	Female
		40-65	25-40
Percentage of Women Afflicted	0.391% of the total female population		

Village	DewanGaon		
Total Population	Male	Female	
	764	549	
Total no. of Probable Cases	Male	Female	
	5	4	
Total no. of Common Cases	Male	Female	
	3	3	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	Who suffers from fits or loss of consciousness?		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	3:2	Male	Female
		25-40	22-50
Percentage of Women Afflicted	0.364% of the total female population		

Village	Bam Kukurasuwa		
Total Population	Male	Female	
	836	678	
Total no. of Probable Cases	Male	Female	
	6	5	
Total no. of Common Cases	Male	Female	
	3	4	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	Who is mad, talk's nonsense and acts in a strange manner?		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	2:1	Male	Female
		30-60	20-58
Percentage of Women Afflicted	0.295% of the total female population		

Village	KorchoguriGohaiGaon	
Total Population	Male	Female
	652	588
Total no. of Probable Cases	Male	Female
	5	6
Total no. of Common Cases	Male	Female
	4	4
Avg. No. of Probable Symptoms	5	
Most Common Symptoms	Who is mad, talk's nonsense and acts in a strange manner?	
Prevalence Rate	Gender Specific (M:F)	Age Specific
	2:3	Male: 20-60; Female: 20-50
Percentage of Women Afflicted	0.510% of the total female population	

Village	Komarkhatowal	
Total Population	Male	Female
	973	817
Total no. of Probable Cases	Male	Female
	5	5
Total no. of Common Cases	Male	Female
	4	2
Avg. No. of Probable Symptoms	5	
Most Common Symptoms	Who is mad, talk's nonsense and acts in a strange manner?	
Prevalence Rate	Gender Specific (M:F)	Age Specific
	1:2	Male: 20-60; Female: 20-50
Percentage of Women Afflicted	0.489% of the total female population	

Village	CinnamaraBor Bangla	
Total Population	Male	Female
	768	569
Total no. of Probable Cases	Male	Female
	3	5
Total no. of Common Cases	Male	Female
	1	2
Avg. No. of Probable Symptoms	5	
Most Common Symptoms	Who is mad, talk's nonsense and acts in a strange manner?	
Prevalence Rate	Gender Specific (M:F)	Age Specific
	3:4	Male: 20-60; Female: 20-65
Percentage of Women Afflicted	0.703% of the total female population	

Village	CinnamaraSadar		
Total Population	Male	Female	
	834	726	
Total no. of Probable Cases	Male	Female	
	3	6	
Total no. of Common Cases	Male	Female	
	1	1	
Avg. No. of Probable Symptoms	4		
Most Common Symptoms	Who is mad, talk's nonsense and acts in a strange manner?		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	1:2	Male	Female
		20-40	28 -57
Percentage of Women Afflicted	0.826% of the total female population		

Village	Cinnamara Buddha Mandir		
Total Population	Male	Female	
	570	423	
Total no. of Probable Cases	Male	Female	
	5	6	
Total no. of Common Cases	Male	Female	
	4	2	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	Who is mad, talk's nonsense and acts in a strange manner?		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	2:5	Male	Female
		30-58	22- 55
Percentage of Women Afflicted	1.182% of the total female population		

Village	Na Ali KamalabariaGaon		
Total Population	Male	Female	
	965	867	
Total no. of Probable Cases	Male	Female	
	5	5	
Total no. of Common Cases	Male	Female	
	3	4	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	Who is mad, talk's nonsense and acts in a strange manner?		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	3:2	Male	Female
		18 - 50	18 -55
Percentage of Women Afflicted	0.231% of the total female population		

Village	Cinnamara TE 2 no. Line	
Total Population	Male	Female
	666	503
Total no. of Probable Cases	Male	Female
	3	5
Total no. of Common Cases	Male	Female
	2	3
Avg. No. of Probable Symptoms	3	
Most Common Symptoms	Who is mad, talk's nonsense and acts in a strange manner?	
Prevalence Rate	Gender Specific (M:F)	Age Specific
	2:3	Male: 25 - 40
		Female: 18 - 45
Percentage of Women Afflicted	0.596% of the total female population	

KAMRUP DISTRICT

Village	Behua	
Total Population	Male	Female
853	428	425
Total no. of Probable Cases	Male	Female
18	10	8
Total no. of Common Cases	Male	Female
3	2	1
Avg. No. of Probable Symptoms	2	
Most Common Symptoms	Who is mad, talk's nonsense and acts in a strange manner	
Prevalence Rate	Gender Specific (M:F)	Age Specific
	9:8	Male: 50
		Female: 30
Percentage of Women Afflicted	1.882% of the total female population	

Village	Dilinga	
Total Population	Male	Female
1240	621	619
Total no. of Probable Cases	Male	Female
14	7	7
Total no. of Common Cases	Male	Female
4	2	2
Avg. No. of Probable Symptoms	4	
Most Common Symptoms	Who has lost his memory or is losing is memory, who is very suspicious and claims that some people are trying to harm him	
Prevalence Rate	Gender Specific (M:F)	Age Specific
	1:1	Male: 35
		Female: 40
Percentage of Women Afflicted	0.969% of the total female population	

Village	Hahim	
Total Population	Male	Female
886	431	458
Total no. of Probable Cases	Male	Female
17	8	9
Total no. of Common Cases	Male	Female
2	0	2
Avg. No. of Probable Symptoms	4	
Most Common Symptoms	Who has become very quiet and does not talk to people, who claims to hear or see things which others cannot see	
Prevalence Rate	Gender Specific (M:F)	Age Specific
	1:1	Male / Female
		50 / 30
Percentage of Women Afflicted	1.747% of the total female population	

Village	Pakhrapara	
Total Population	Male	Female
1243	619	624
Total no. of Probable Cases	Male	Female
14	7	7
Total no. of Common Cases	Male	Female
2	1	1
Avg. No. of Probable Symptoms	5	
Most Common Symptoms	Who is mad, talk's nonsense and acts in a strange manner	
Prevalence Rate	Gender Specific (M:F)	Age Specific
	1:1	Male / Female
		50 / 30
Percentage of Women Afflicted	1.122% of the total female population	

Village	Dakuwapara	
Total Population	Male	Female
3016	1525	1491
Total no. of Probable Cases	Male	Female
12	3	9
Total no. of Common Cases	Male	Female
3		
	0	3
Avg. No. of Probable Symptoms	5	
Most Common Symptoms	Who suffers from fits or loss of consciousness, Who is mad, talk's nonsense and acts in a strange manner	
Prevalence Rate	Gender Specific (M:F)	Age Specific
	3:7	Male / Female
		40 / 30
Percentage of Women Afflicted	0.469% of the total female population	

Village	Gerua	
Total Population	Male	Female
1060	567	493
Total no. of Probable Cases	Male	Female
15	9	6
Total no. of Common Cases	Male	Female
4	3	1
Avg. No. of Probable Symptoms	4	
Most Common Symptoms	Who claims to hear or see things which others cannot see	
Prevalence Rate	Gender Specific (M:F)	Age Specific
	7:6	Male / Female
		35 / 30
Percentage of Women Afflicted	1.217% of the total female population	

Village	Monahkuchi		
Total Population	Male	Female	
6290	3206	3084	
Total no. of Probable Cases	Male	Female	
15	4	11	
Total no. of Common Cases	Male	Female	
4	2	2	
Avg. No. of Probable Symptoms	6		
Most Common Symptoms	Who suffers from fits or loss of consciousness, Who is mad, talk's nonsense and acts in a strange manner		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	3:10	Male	Female
		55	25
Percentage of Women Afflicted	0.324% of the total female population		

Village	Kalitakuchi		
Total Population	Male	Female	
3650	1878	1722	
Total no. of Probable Cases	Male	Female	
12	4	8	
Total no. of Common Cases	Male	Female	
4	1	3	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	Who is admitted to Mental Hospital, Who is mad, talk's nonsense and acts in a strange manner		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	2:3	Male	Female
		55	40
Percentage of Women Afflicted	0.348% of the total female population		

Village	Bardadhi		
Total Population	Male	Female	
2994	1522	1472	
Total no. of Probable Cases	Male	Female	
12	3	9	
Total no. of Common Cases	Male	Female	
4	1	3	
Avg. No. of Probable Symptoms	6		
Most Common Symptoms	Who is mad, talk's nonsense and acts in a strange manner, Who claims to hear or see things which others cannot see		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	3:7	Male	Female
		60	35
Percentage of Women Afflicted	0.475% of the total female population		

Village	Hadala		
Total Population	Male	Female	
1370	725	645	
Total no. of Probable Cases	Male	Female	
16	8	8	
Total no. of Common Cases	Male	Female	
3	1	2	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	Who is mad, talk's nonsense and acts in a strange manner		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	8:7	Male	Female
		40	25
Percentage of Women Afflicted	1.085% of the total female population		

SONITPUR DISTRICT

Village	PATHEKAKURI		
Total Population	Male	Female	
	516	502	
Total no. of Probable Cases	Male	Female	
	6	14	
Total no. of Common Cases	Male	Female	
	3	9	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	2,4 & 14		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	2:3	Male	Female
		44	50
Percentage of Women Afflicted	1.195% of the total female population		

Village	Habidoloni		
Total Population	Male	Female	
	557	547	
Total no. of Probable Cases	Male	Female	
	11	10	
Total no. of Common Cases	Male	Female	
	3	2	
Avg. No. of Probable Symptoms	3		
Most Common Symptoms	2&14		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	1:1	Male	Female
		36	45
Percentage of Women Afflicted	1.645% of the total female population		

Village	Bhuyanpara		
Total Population	Male	Female	
	519	488	
Total no. of Probable Cases	Male	Female	
	6	10	
Total no. of Common Cases	Male	Female	
	2	3	
Avg. No. of Probable Symptoms	6		
Most Common Symptoms	2,3,4&15		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	5:8	Male	Female
		48	41
Percentage of Women Afflicted	1.639% of the total female population		

Village	Ghahigaon		
Total Population	Male	Female	
	1209	1148	
Total no. of Probable Cases	Male	Female	
	9	9	
Total no. of Common Cases	Male	Female	
	4	4	
Avg. No. of Probable Symptoms	6		
Most Common Symptoms	13&14		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	1:1	Male	Female
		29	48
Percentage of Women Afflicted	0.523% of the total female population		

Village	Hokajan		
Total Population	Male	Female	
	500	479	
Total no. of Probable Cases	Male	Female	
	6	6	
Total no. of Common Cases	Male	Female	
	1	1	
Avg. No. of Probable Symptoms	4		
Most Common Symptoms	2,3 & 4		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	1:1	Male	Female
		43	48
Percentage of Women Afflicted	1.252% of the total female population		

Village	Gore hagi		
Total Population	Male	Female	
	813	803	
Total no. of Probable Cases	Male	Female	
	5	8	
Total no. of Common Cases	Male	Female	
	3	6	
Avg. No. of Probable Symptoms	8		
Most Common Symptoms	3&6		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	1:1	Male	Female
		40	44
Percentage of Women Afflicted	0.374% of the total female population		

Village	PaniBhoral		
Total Population	Male	Female	
	701	707	
Total no. of Probable Cases	Male	Female	
	8	4	
Total no. of Common Cases	Male	Female	
	6	3	
Avg. No. of Probable Symptoms	6		
Most Common Symptoms	2 & 14		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	3:2	Male	Female
		47	36
Percentage of Women Afflicted	0.283% of the total female population		

Village	Bali Pukhuri		
Total Population	Male	Female	
	1220	1208	
Total no. of Probable Cases	Male	Female	
	6	11	
Total no. of Common Cases	Male	Female	
	3	6	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	4&9		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	2:3	Male	Female
		37	46
Percentage of Women Afflicted	0.497% of the total female population		

Village	BhirGaon		
Total Population	Male	Female	
	2191	2141	
Total no. of Probable Cases	Male	Female	
	4	10	
Total no. of Common Cases	Male	Female	
	3	5	
Avg. No. of Probable Symptoms	6		
Most Common Symptoms	9&14		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	1:3	Male	Female
		34	40
Percentage of Women Afflicted	0.280% of the total female population		

Village	MaralGaon		
Total Population	Male	Female	
	795	797	
Total no. of Probable Cases	Male	Female	
	5	8	
Total no. of Common Cases	Male	Female	
	2	4	
Avg. No. of Probable Symptoms	5		
Most Common Symptoms	2&9		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	4:5	Male	Female
		40	35
Percentage of Women Afflicted	0.627% of the total female population		

TINSUKIA DISTRICT

Village	LesengkaBongaliGaon		
Total Population	Male	Female	
1,891	945	946	
Total no. of Probable Cases	Male	Female	
5	1	4	
Total no. of Common Cases	Male	Female	
	1	1	
Avg. No. of Probable Symptoms	7		
Most Common Symptoms	6		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
0.26441	1:4	Male	Female
		39	39.5
Percentage of Women Afflicted	0.423% of the total female population		

Village	Bengenabari		
Total Population	Male	Female	
Total no. of Probable Cases	Male	Female	
6	1	5	
Total no. of Common Cases	Male	Female	
	1	1	
Avg. No. of Probable Symptoms	6		
Most Common Symptoms	6		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
	1:5	Male	Female
Percentage of Women Afflicted			

Village	Hansara		
Total Population	Male	Female	
1709	827	882	
Total no. of Probable Cases	Male	Female	
7	-	7	
Total no. of Common Cases	Male	Female	
	-	1	
Avg. No. of Probable Symptoms	6		
Most Common Symptoms	5		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
0.4096	0:7	Male	Female
		-	40
Percentage of Women Afflicted	0.794% of the total female population		

Village	Anandabagh T.E.		
Total Population	Male	Female	
1,508	713	795	
Total no. of Probable Cases	Male	Female	
5	1	4	
Total no. of Common Cases	Male	Female	
	1	1	
Avg. No. of Probable Symptoms	6		
Most Common Symptoms	5		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
0.33156	1:4	Male	Female
		35	38.25
Percentage of Women Afflicted	0.503% of the total female population		

Village	Dighaltarang T.E		
Total Population	Male	Female	
1431	711	720	
Total no. of Probable Cases	Male	Female	
7	3	5	
Total no. of Common Cases	Male	Female	
	3	1	
Avg. No. of Probable Symptoms	6,3		
Most Common Symptoms	6		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
0.55905	1:4	Male	Female
		32.66	40.2
Percentage of Women Afflicted	0.555% of the total female population		

Village	Monkhooli		
Total Population	Male	Female	
1959	900	1059	
Total no. of Probable Cases	Male	Female	
6	1	5	
Total no. of Common Cases	Male	Female	
	1	2	
Avg. No. of Probable Symptoms	6		
Most Common Symptoms	5		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
0.30628	1:4	Male	Female
		32	39
Percentage of Women Afflicted	0.378% of the total female population		

Village	Dewhaal		
Total Population	Male	Female	
477	233	244	
Total no. of Probable Cases	Male	Female	
5	1	4	
Total no. of Common Cases	Male	Female	
	1	1	
Avg. No. of Probable Symptoms	7		
Most Common Symptoms	7		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
1.04822	1:4	Male	Female
		37	38.75
Percentage of Women Afflicted	1.639% of the total female population		

Village	BahadurBagaan		
Total Population	Male	Female	
1694	824	870	
Total no. of Probable Cases	Male	Female	
7	1	6	
Total no. of Common Cases	Male	Female	
	1	1	
Avg. No. of Probable Symptoms	6		
Most Common Symptoms	6		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
0.41322	1:6	Male	Female
		75	34.83
Percentage of Women Afflicted	0.689% of the total female population		

Village	Borjaan		
Total Population	Male	Female	
1785	921	864	
Total no. of Probable Cases	Male	Female	
5	1	4	
Total no. of Common Cases	Male	Female	
	1	1	
Avg. No. of Probable Symptoms	7,2		
Most Common Symptoms	6		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
0.28011	1:4	Male	Female
		39	34
Percentage of Women Afflicted	0.463% of the total female population		

Village	Mahakali T.E.		
Total Population	Male	Female	
4,792	2384	2408	
Total no. of Probable Cases	Male	Female	
5	1	4	
Total no. of Common Cases	Male	Female	
	1	1	
Avg. No. of Probable Symptoms	6		
Most Common Symptoms	6		
Prevalence Rate	Gender Specific (M:F)	Age Specific	
0.10434	1:4	Male	Female
		36	40.75
Percentage of Women Afflicted	0.166% of the total female population		

Note: For details of the most common symptoms refer to IPSS form in Appendix III, page no. 120.

Appendix III

INITIAL PERFORMA FOR SCREENING (IPSS)

SL No:
House No:

Head of the house: Age: Sex (M/F):
Education: Livelihood: Socio-Economic:
Village: Family: Nuclear/Joint Annual Income of the family:
Name of the Grass Root Worker:
In your family or neighbours' or among friends, is there anyone –

		Yes (Y)	No (N)	No Knowledge (NK)
1.	Who is admitted to Mental Hospital?			
2.	Who is mad, talk's nonsense and acts in a strange manner?			
3.	Who suffers from fits or loss of consciousness?			
4.	Who has become very quiet and does not talk to people?			
5.	Who claims to hear or see things which others cannot see?			
6.	Who is very suspicious and claims that some people are trying to harm him?			
7.	Who has become unusually cheerful, makes jokes and brags that he is a big man?			
8.	Who has become very sad lately and cries without reason?			
9.	Who has lost his memory or is losing his memory?			
10.	Who has always since birth been stupid or dull like a child?			
11.	Who has tried to commit suicide?			
12.	Who actually committed suicide?			
13.	Who gets possessed by ghost and spirits?			
14.	Who is lazy and does not work through physically healthy?			
15.	Who drinks too much or gambles too much or has other bad habits?			

Name of the persons who has the above symptoms:

1……Age…….Sex (M/F)……..Occupation…..……Education…….

2……Age…….Sex (M/F)……..Occupation…..……Education…….

3……Age…….Sex (M/F)……..Occupation…..……Education…….

Signature of the Head of the family Grass Root Worker's Signature

KEY INFORMANTS: Pharmacists/ Shop keepers, Village Headman, ASHA workers/Anganwadi workers, School teachers, Panchayat secretary/ president/ members/ ward members, Social activists/ youth leaders/ community workers/ SHGs, Patients' family/ relatives/ neighbours, Priests/ faith healers/ local doctors, Cultural clubs/ forums/ members, Village elders/ reputed people