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COMMUNITY ENGAGEMENT, SOCIAL CONNECTEDNESS AND MENTAL WELL-BEING AMONG RURAL COMMUNITIES IN AMROHA, UTTAR PRADESH

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ABSTRACT

Mental health remains a major public health concern in rural communities, where psychological well-being may be affected by low awareness, social stigma, limited access to mental health treatments, and insufficient community-level support, mental health remains a major public health concern. Developing supportive environments for mental health awareness and encouraging positive attitudes about seeking treatment can be significantly supported by social connectivity and community engagement. However, there is still an absence of research on community-based mental health programs in rural areas. The aim of this study is to investigate the relationship between mental well-being, social connectedness, and community engagement in rural communities in Amroha, Uttar Pradesh. Additionally, the study will look at how community-based mental health awareness initiatives can improve mental health awareness and engagement.

A community-based study was undertaken in selected rural areas of Amroha district, Uttar Pradesh, through Mansarthi, a mental health awareness initiative taken by the author, involving community level awareness activities and interaction with rural residents. The initiative's primary objectives included raising awareness of mental health issues, removing stigma and misconceptions, promoting open conversation, and educating participants on the value of getting the right mental health care. A standardized questionnaire measuring community involvement, social connectivity, mental health awareness, and mental well-being was used to gather data from participating community members including age groups from 6 years to 60 years of a sample size of 85, which was then analysed.

The study investigates whether higher levels of social connectedness and community involvement are linked to improved mental health among people living in rural areas. It also evaluates changes in mental-health awareness and attitudes following participation in the Mansarthi awareness programs.

The study underlines the importance of rural mental health. The findings may also provide insights for establishing community-oriented mental-health awareness programs that are accessible, socially responsive, and relevant to rural situations.

The study highlights the importance of community-based approaches addressing mental health awareness and promoting psychological well-being in rural communities. By analysing the relationship between community engagement, social connectedness and mental well-being. The study may contribute to understanding of how locally based initiatives can support mental health in rural areas. The results may also provide suggestions for developing community oriented mental health awareness programmes that are accessible, socially responsive and appropriate to rural contexts.

Keywords: Mental Health, Community Engagement, Social Connectedness, Rural Communities

1 INTRODUCTION

Mental health is an essential component of overall health and wellbeing includes emotional, psychological and social dimensions of human behaviour. The World Health Organization (WHO) recognizes mental health as a condition of well-being that helps individuals to cope with everyday stressors, realize their strengths, learn and work productively, and contribute to their communities. In addition to individual characteristics, social, economic, environmental, and communal situations can have an impact on mental health. As a result, comprehending mental health necessitates paying attention to the social contexts in which people live and engage.

People's experiences of psychological well-being may be influenced by social relationships, community involvement, cultural practices, and access to help, making rural areas a significant environment for studying mental health. Research on rural mental health has revealed various hurdles to seeking and interacting with mental-health care, including limited availability of services, stigma, concerns surrounding confidentiality, transportation challenges, and lack of understanding about available support (McCarthy et al., 2021). However, disadvantage should not be the only way that rural areas are perceived. They vary in social settings with their own interpersonal connections, cultural customs, social networks, and modes of group involvement. These current social services could offer significant chances to improve mental health awareness and wellbeing.

In this context, social connectedness is becoming more widely acknowledged as an essential component of mental health. The degree to which people feel acceptance, connection, and meaningful interactions with others is referred to as social connectedness. While social separation can be linked to worse mental health, stronger social ties can offer practical and emotional assistance and may lead to improved psychological results (Hare-Duke et al., 2019). Significantly, participating in social events. While individuals may engage in structured community activities without feeling a strong sense of belonging, others may find significant social support through interactions with family or interpersonal relationships.

Another essential component of studying mental health in rural areas is community involvement. Engaging in community events can foster communication, group problem-solving, knowledge sharing, and support for one another. Community-based approaches to mental health have increasingly stressed the value of collaborating with local communities and providing accessible, socially responsive types of mental-health support (WHO, 2021). However, depending on the social and cultural environment, the relationship between social connectedness, community involvement, and mental health can differ. Therefore, a rural mental mind is the mental comprehension of the community.

There is a need for mental populations that are mental populations that are related to India. The present research looks at the connection between social connectivity, mental health, and community engagement in a few rural areas in Amroha, Uttar Pradesh.

The Amroha district in western Uttar Pradesh provides a relevant context for examining community relationships and mental health because of its broad network of rural settlements and culturally diverse social landscape, which is shaped by agriculture, traditional occupations, religious practices, and group events like the Tigri Ganga Mela. Family relationships, neighbourhood interactions, community involvement, and local social networks may all contribute to feelings of support and belonging in this context, but further research is needed to establish how these factors relate to mental health.

The study is part of Mansarthi, the author's community-based mental health awareness initiative that involves engagement with rural residents and awareness-raising events. Thus, the purpose of this study is to identify whether social connectedness and community involvement are related to participants' mental health in rural areas. It also examines changes in mental-health awareness and attitudes following participation in the Mansarthi awareness programs. The study aims to develop a context-sensitive knowledge of community-based approaches to mental health in rural India by integrating community participation, social connection, mental-health awareness, and mental well-being. The study is to analyse the relationship between community engagement, social connectedness and mental well-

being among adults in rural communities of Amroha, Uttar Pradesh. The results could provide helpful information for creating accessible, socially conscious, and rural-appropriate mental health awareness initiatives.

Although community-based awareness events are generally perceived to encourage openness and support, participation alone does not infer that people feel more connected or experience higher mental well-being. Therefore, context-specific research is needed to understand the correlations between involvement, connectedness, awareness, help-seeking attitudes and perceived well-being in rural Indian contexts.

The existing literature study highlights the significance of social connections and community settings for mental health; however, there is still a necessity for context-specific empirical studies investigating the relationship between community involvement and social ties with mental well-being in rural Indian populations. In particular, community engagement and perceived social unity should be analyzed as interrelated yet separate aspects, since involvement in community activities does not inherently result in significant perceptions of belonging or support. This study aims to explore the relationship between community involvement, social bonds, and mental health among individuals in certain rural areas of Amroha, Uttar Pradesh, as part of the community-driven mental health awareness program, Mansarthi.

2 LITERATURE REVIEW

2.1 Mansarthi

The Mansarthi is a mental health awareness initiative launched by the author in rural areas of Amroha district. The initiative includes community level awareness and outreach programs with residents of the villages of Amroha district to address misunderstandings, define mental health and encourage an increased awareness of emotional wellness and the importance of appropriate mental health support.

The initiative emphasizes that family interactions, social environments, and community attitudes all have an impact on mental health. Community relationships and dependable social networks can offer chances to exchange information, talk about issues, and motivate people to get the help they need in rural areas. Mansarthi provides a setting for examining the connection between social connectivity, mental health, and community involvement through awareness initiatives and interaction with rural residents.

Mansarthi's community-oriented methodology makes it relevant to the present study. The study takes into account how awareness activities may connect to participants' feelings of social support, attitudes toward getting help, and understanding of mental health rather than treating awareness as an outcome in and of itself. It also acknowledges that awareness by itself cannot remove every obstacle to care, especially in cases where social stigma, expenses, confidentiality, or access to skilled professionals are still issues. The opportunities to improve locally responsive awareness programs and connect community-level activities with suitable mental health providers may be found through the study. However, any conclusions about the efficacy or impact of Mansarthi must be supported by the empirical results of the study and a suitable evaluation design.

2.1.1 Mental Health and Well-Being

Mental health issues can be particularly significant in rural and resource-limited areas, where individuals may face obstacles concerning the availability, accessibility, pricing, and acceptance of mental health care. Geographical distance, restricted access to specialized services, socioeconomic factors, societal conventions, and stigma might affect persons' awareness of mental health issues and their pursuit of assistance. Mental-health awareness can contribute to an individual's ability to recognize indicators of psychological distress, comprehend accessible sources of support, question misunderstandings, and make educated decisions regarding help-seeking. Early detection of mental-health difficulties may promote timely support and lessen the chance of problems staying hidden.

However, awareness alone does not assure ability to obtain mental-health care. An individual may identify a mental-health condition and be prepared to seek treatment, yet still experience barriers such as limited local options, financial limits, transportation challenges, lack of skilled professionals, or worries about confidentiality and stigma. Therefore, enhancing mental-health outcomes needs consideration of both individual/community understanding and the accessibility of appropriate support services.

Within this environment, community participation may provide an important platform for enhancing mental-health awareness and social connectedness in rural areas. Community-based projects can provide spaces where individuals discuss mental health, exchange experiences, access information, and become familiar with various sources of support. The Mansarthi initiative undertaken in randomly selected rural regions of Amroha, Uttar Pradesh, provides a context for examining how community-level mental-health awareness efforts interact with community engagement and social connectivity. Accordingly, the present study investigates the relationship between community participation, social

connectedness, and mental well-being among rural communities in Amroha, while also evaluating the influence of community-based mental-health awareness programs.

2.1.2 Mental Health in Rural Communities

Rural communities are defined by different social, cultural, economic, and geographical contexts, and mental health within these settings cannot be understood only in terms of the availability or lack of mental-health services. Mental health is considered by the World Health Organization (WHO) as a condition of mental well-being that enables individuals to cope with the demands of life, realize their skills, work productively, and contribute to their communities (World Health Organization, 2026). Mental health therefore depends not just by individual circumstances but also by family, community, social, economic, and structural variables (World Health Organization, 2026).

Access to appropriate mental-health support may be influenced by the availability and accessibility of services, geographical distance, affordability, transportation, and the availability of skilled academic and professional resources.

Evidence from research on rural settings reveals that stigma, proximity of services, and the nature of existing support structures and social ties can influence experiences of receiving mental-health care (McCarthy et al., 2021). The WHO has also underlined the significance of enhancing primary and community-based approaches to mental-health care, particularly where expert resources are restricted (World Health Organization, 2021). In India, mental-health care has increasingly been incorporated into primary-healthcare settings, in particular through Health and Wellness Centres, reflecting efforts to spread services beyond specialist institutions.

Awareness is another essential component of mental health in rural areas. Mental-health literacy can influence an individual's ability to recognize psychological disorders, grasp various sources of support, and make educated decisions on help-seeking. However, awareness should not be considered comparable with access to care. An individual may perceive a mental-health condition and still experience practical difficulties related to cost, distance, availability of professionals, or the acceptance of formal services. Research on rural mental-health access has found stigma and the remoteness of resources among key barriers to help-seeking, while also underlining the relevance of social support and connectedness within rural communities (McCarthy et al., 2021).

Social and cultural variables may further impact how mental health is regarded and discussed. Family relationships, community networks, social expectations, and culturally molded understandings of psychiatric suffering can influence whether individuals seek official treatments or initially turn toward informal sources of support. Stigma and prejudice related with mental-health problems remain serious concerns globally (World Health Organization, 2026). At the same time, families, peers, and community networks can give essential types of emotional and practical support. Consequently, rural communities should not be understood exclusively through a deficit-oriented perspective; their existing social interactions and community structures could serve as resources for mental-health promotion. This is consistent with the increased emphasis on community-based mental-health methods that engage families, communities, primary healthcare systems, and non-specialist support structures (World Health Organization, 2021).

Consequently, understanding mental well-being in rural settings involves consideration to both possible limitations and current community strengths. Examining community engagement, social interactions, and connectedness alongside mental-health awareness can provide a better contextual understanding of how individuals perceive and support mental well-being. This approach offers the basis for assessing community participation and social connectivity in the present study.

2.1.3 Community Engagement and Mental Health

Community engagement broadly refers to the ways in which individuals participate in, interact with, and contribute to the social and collective life of their communities. Within the present study, community engagement encompasses participation in local events, interaction with community members, involvement in collective efforts, volunteering or helping behaviours, participation in awareness efforts, and other forms of active community involvement. Such participation can generate opportunities for social contact, mutual support, shared experiences, and the development of social relationships.

The relationship between community participation and mental health can be understood within the broader literature on social connection and community-based mental-health development. The WHO regards social connection as an important feature of health and explains social connection as comprising the ways individuals relate to and engage with others, including the support and resources available through those interactions (World Health Organization, 2025). Similarly, community-based mental-health programs emphasize the engagement of communities and families in improving mental health, acknowledging mental health concerns, and connecting individuals with appropriate support (World Health Organization, 2021).

However, determining the nature, frequency, inclusiveness, and quality of community participation may influence its correlation with psychological well-being. Community engagement should therefore not be viewed as inherently resulting in favourable mental-health outcomes. The present study accordingly explores community engagement as an empirical construct, concentrating on participation, interaction, collective involvement, helping conduct, and participation in community-based awareness activities within selected rural communities of Amroha, Uttar Pradesh.

2.1.4 Social Connectedness and Mental Well-Being

Social connectedness refers to an individual's perceived sense of belonging and meaningful connection with other people and social groups. It involves the quality and character of social relationships, perceived availability of support, interactions with family and community members, and the extent to which individuals feel valued and included within their social environment. The concept is broader than the basic number or frequency of social connections. A person can be surrounded by others and still feel alone; conversely, a small and trusted network may provide significant support. The WHO Commission on Social Connection (2025) underlines the importance of social connection for health and well-being and urges for improved monitoring, research and community action.

Accordingly, the present study examines whether community engagement and social connectedness are associated with mental well-being among adults in selected rural communities of Amroha, Uttar Pradesh, while considering the role of community-based mental-health awareness activities such as Mansarthi within this context.

3 CONCEPTUAL FRAMEWORK

The proposed interdisciplinary paradigm treats community participation as a potential opportunity for interaction, not as a guaranteed mental-health approach. Social connectivity is a tentative avenue associating engagement with perceived well-being. Mental-health awareness might influence recognition of distress and understanding of help-seeking alternatives, while service accessibility, stigma, affordability and confidentiality concerns may determine whether information can be translated into action.

The fundamental theoretical framework of the research analyzes how three related factors may interact:

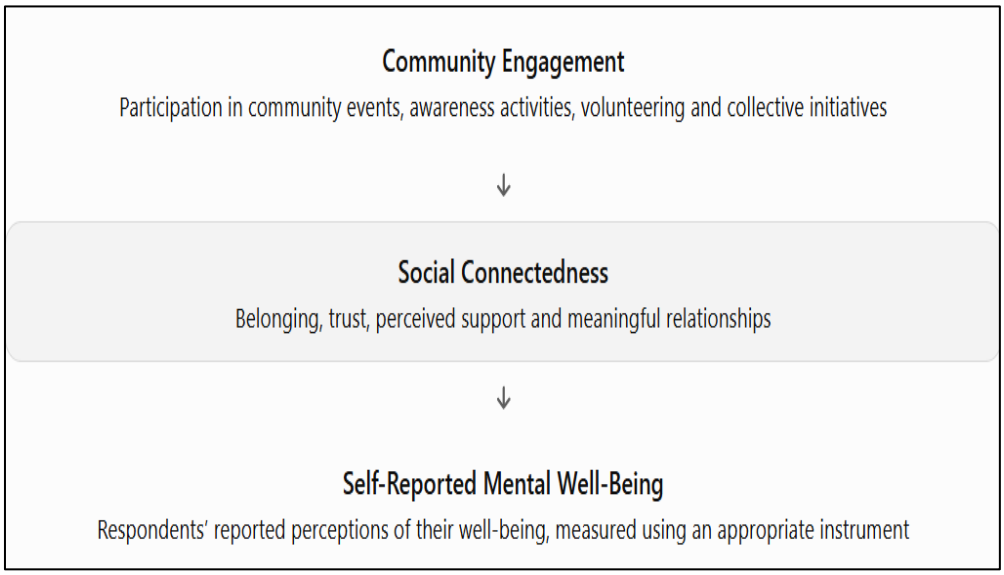


Figure 1: Conceptual Framework Linking Community Engagement, Social Connectedness, and Self-Reported Mental Well-Being. Source: Author's own conceptualisation, w.r.t. Cohen and Wills (1985), Kawachi and Berkman (2001), Holt-Lunstad (2022), and Russell et al. (2023).

Through enhanced connections, trust, a sense of belonging, and perceived support, the framework demonstrates how engaging in community activities can promote social connectedness. Better self-reported mental well-being among rural respondents may be linked to these social ties.

Table 1: Operationalisation of Key Framework Components, Measurement Indicators, and Analytical Roles, ***Source: Author***

Framework component	What to measure	Analytical role
Community engagement	Frequency of attendance; volunteering/helping; participation in awareness events	Describes opportunities for contact and shared activity
Social connectedness	Belonging; trust; perceived support; someone to talk to	Captures perceived quality of social relationships
Mental-health awareness	Recognition of concerns; knowledge of support sources; attitudes to help-seeking	Indicates awareness and knowledge, not service use by itself
Contextual barriers	Stigma; confidentiality; distance; cost; service availability; information	May constrain help-seeking and participation benefits
Self-reported mental well-being	A suitable validated well-being measure or clearly labelled self-rating	Describes perceived well-being; not a clinical diagnosis

Table 1. shows the main elements of the study framework, the indicators that are utilized to look at each element, and the analytical functions that each element plays in comprehending mental health in rural areas. It treats self-reported well-being as a gage of subjective well-being rather than a clinical diagnosis and separates community involvement, social connectivity, and mental health awareness from contextual barriers.

4 RESEARCH METHODOLOGY

4.1 Research design

A community-oriented, cross-sectional survey methodology is appropriate for delineating existing trends and investigating connections. If the empirical research collected responses before and subsequent to a Mansarthi activity, a paired pre/post design might be delineated in its entirety, encompassing the count of matched responses and the exact date.

4.2 Study area and participants

The research is conducted in certain rural communities within the 5 villages namely, Kheda, Apraula, Makhdumpur, Peelakund and Badshahpur, district Amroha of Uttar Pradesh. The original manuscript had 85 individuals ranging in age from 6 to 60 years. The example graphs in this paper show how a dataset of 40 respondents could be presented.

4.3 Sampling

The sampling was purposive as the selection was taken from all age-groups from 6-60 years old respondents. The respondents were selected randomly from school going category, house wives, the people working in agricultural fields, government school teachers etc. The questionnaire was floated for the survey, in which the non-identifying demographic details were asked, community participation, perceived social connectedness, mental-health awareness and help-seeking attitudes, perceived barriers and access to support and self-reported mental well-being.

4.4 Study Tool

A standard, self-completed questionnaire that was available in both Hindi and English was used to gather data. A trained facilitator read the items aloud to responders who were young children or had inadequate literacy. There are five sections to the questionnaire:

- Demographic data (gender, age group, employment, and level of education).
- Community involvement (5-point Likert scale from 1 = Never to 5 = Always).
- Social connectivity (8 questions on a 5-point Likert scale derived from the Social connectivity Scale idea of closeness and belonging; Lee & Robbins, 1995).
- Mental health (WHO-5 Well-Being Index; Topp et al., 2015). Each item has a score between 0 and 5, which is then multiplied by 4 to get a score between 0 and 100.
- Mental health awareness and attitudes.

5 DATA ANALYSIS

The Microsoft Excel was used to enter the responses, and their completeness was verified. The only basic techniques were employed: frequencies and percentages to characterize respondents and their responses, the average (mean) score on each scale, determined by adding each individual's item scores and averaging across respondents, a comparison of average well-being between respondents with high and low connectedness using the median score as the cut-off, average scores by age group; and a comparison of average awareness scores before and after Mansarthi, with the percentage of respondents whose scores improved.

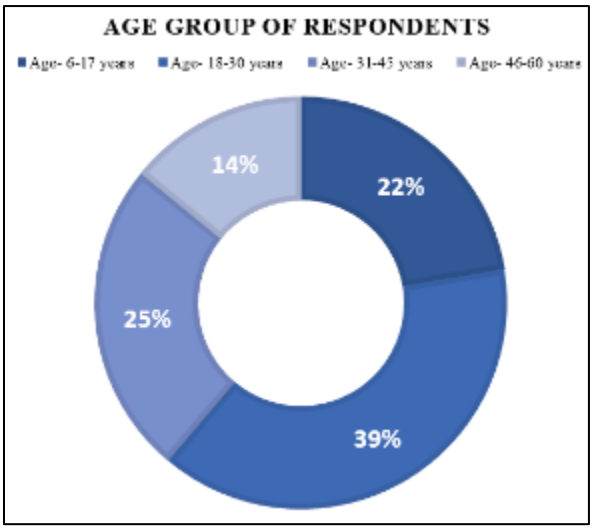


Figure 2: Age distribution (n = 85), *Source: Author*

Figure 2 shows the respondent profile was distributed across four age groups where the largest group was 18-30 years (33%), then 31-45 years (21%), then 6-17 years (19%) and 46-60 years (12%).

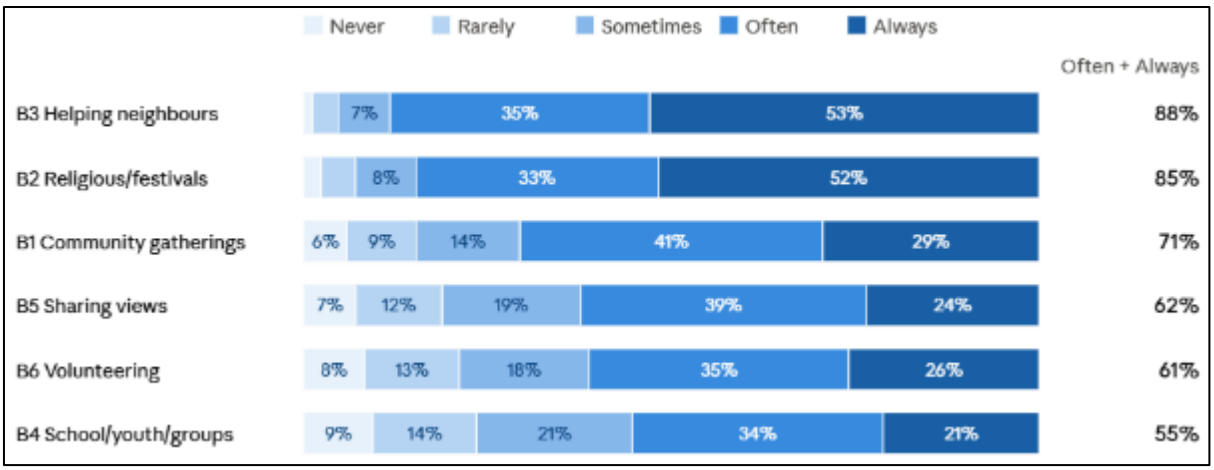


Figure 3: Community engagement: number of respondents by frequency of participation in six community activities (n = 85). *Source: Author*

The frequency with which the 85 respondents participated in six community activities is displayed in Figure 3. Overall, engagement was high. Out of a possible 30, the average engagement score was 23.0 (mean 3.8 per item on a 5-point scale). Responses were focused on "Often" and "Always" for each task.

Traditional and informal activities have the highest participation rates. The greatest ratings (mean 4.35 and 4.27) were obtained for helping neighbors (B3) and participating in religious, cultural, or festival events (B2), with 88% and 85% of respondents responding "often" or "always," and over half responding "always" (53% and 52%). Participating in community events (B1) was also prevalent (71% frequently or always; mean 3.79).

There was less participation in activities that require greater initiative or a structured environment. The lowest percentages of frequent participation were seen in volunteering (B6, 61%), sharing opinions in community

conversations (B5, 62%), and school, youth, or group activities (B4, 55%). With a mean of 3.44 and almost 24% of responders participating little or never, B4 was the weakest.

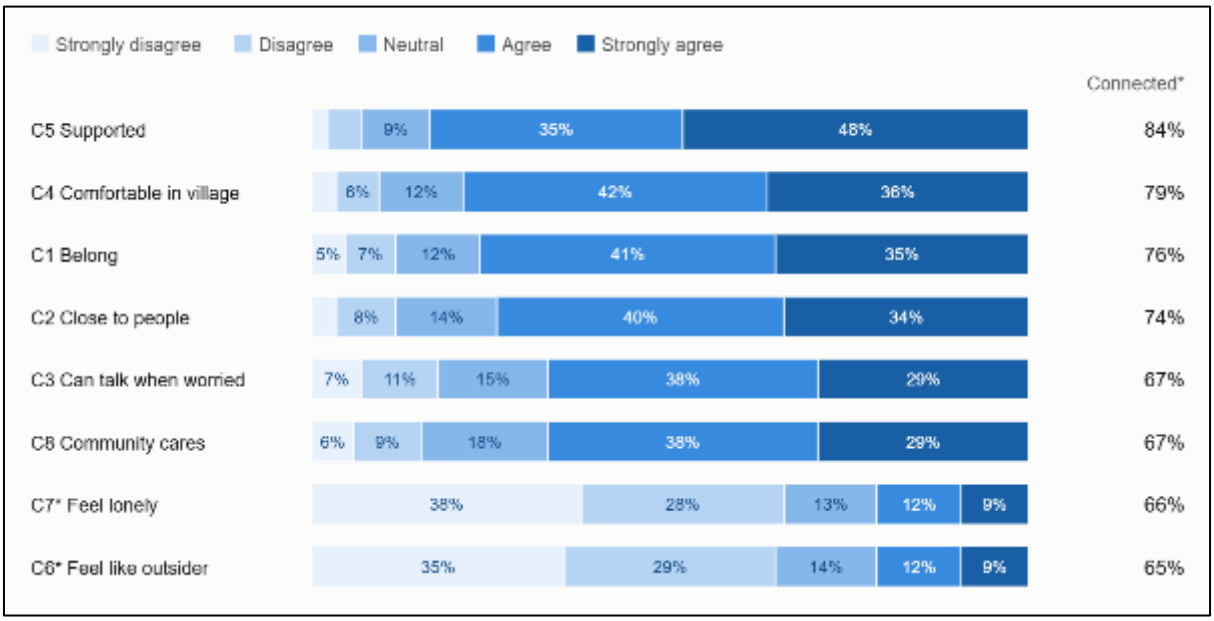


Figure 4: Social connectedness: percentage of respondents by level of agreement on eight items (n = 85). ***Source: Author***

Figure 4 shows each response above 64%, the majority of respondents expressed a strong sense of social connectivity. Support and comfort received the highest ratings; 84% of respondents said they were supported by friends and relatives (C5), and 79% said they felt at ease with villagers (C4). There was also a high level of closeness and belonging, with around three out of four respondents feeling connected to those around them (74%) and belonging to their community (76%). On two issues, connectedness was lower: 67% of respondents stated they have someone to talk to when they're anxious (C3), with roughly 18% disagreeing, and 67% indicated that people in the community look out for one another (C8), with 18% being neutral. About 21% of respondents said they felt lonely most of the time (C7) or like an outsider (C6), indicating that a small percentage also felt alone.

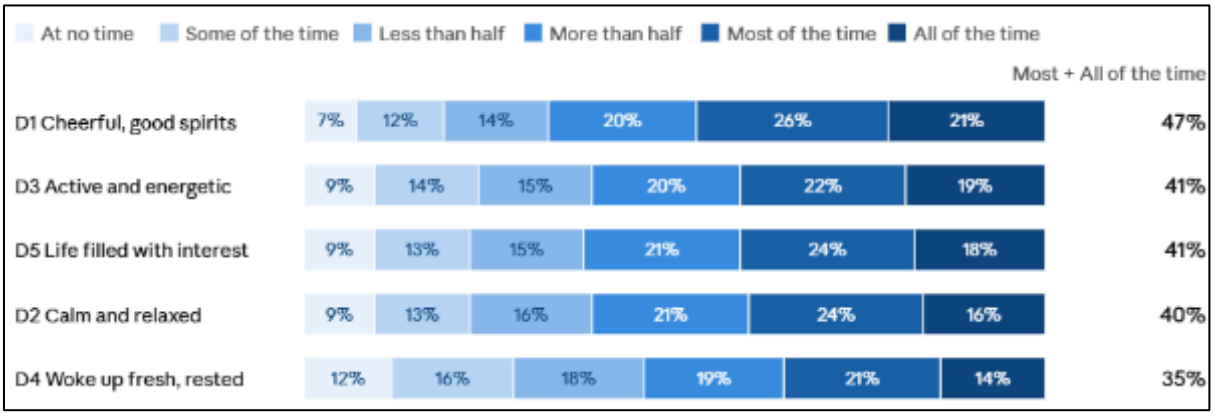


Figure 5: The percentage of respondents by frequency of each emotion during the previous two weeks (n = 85) for mental well-being (WHO-5). ***Source: Author***

The frequency of five elements of well-being among the 85 respondents during the preceding two weeks is displayed in Figure 4. With an average WHO-5 score of 57.5 out of 100, general well-being was modest. 47% of respondents said they were most or always happy and in a good mood (D1). 40–41% of respondents reported feeling calm and relaxed (D2), having a daily life full of interesting things (D5), and feeling active and energetic (D3). The weakest category was "waking up rested and fresh" (D4), with 35% reporting it most or often and 28% reporting it seldom or never.

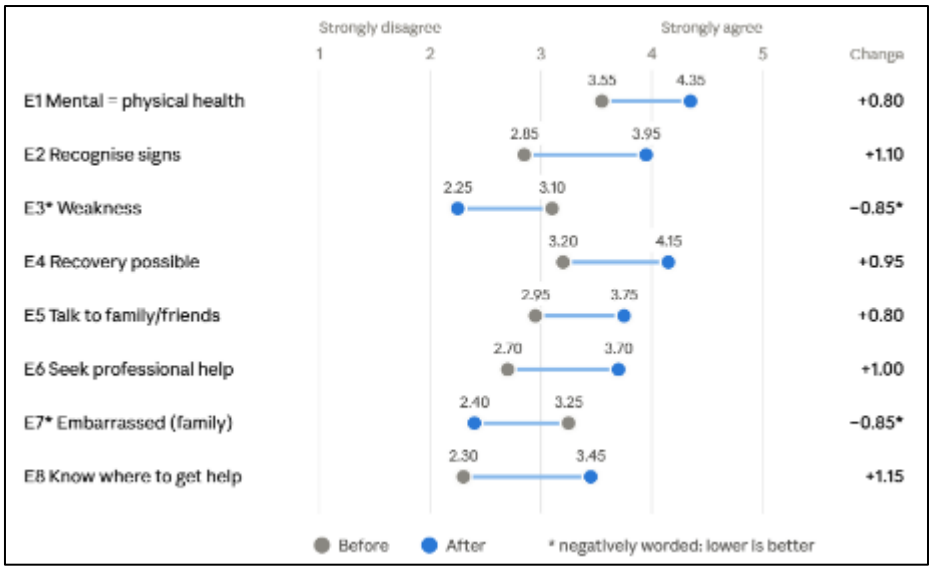


Figure 5: Mean scores on eight mental health awareness and attitude items before and after participation in Mansarthi (n = 85). Grey dots show the mean before and blue dots the mean after; the line joins the two.
Source: Author

The mean scores on eight awareness and attitude items before and after Mansarthi participation are compared in Figure 5. The means increased by 0.80 to 1.15 points on the six positively phrased items. The biggest improvements were in identifying indications of emotional trouble (E2; 2.85 to 3.95, +1.10), understanding where to get local mental health care (E8; 2.30 to 3.45, +1.15), and being willing to seek professional help (E6; 2.70 to 3.70, +1.00). The ease of talking about problems with family or friends (E5), the idea that mental health is just as essential as physical health (E1), and the belief that recovery is feasible with appropriate help (E4) all increased by 0.80. Attitudes toward stigma also shifted in a positive way. Embarrassment if a family member has a mental health issue (E7) decreased from 3.25 to 2.40, and agreement that mental health issues reflect weakness (E3) decreased from 3.10 to 2.25, both of which were reductions of 0.85.

6 DISCUSSION

In the approach of Mansarthi, a community-based mental health awareness campaign, the current study looks at community participation, perceived social connectedness, self-reported mental well-being, and mental health awareness among people of particular rural communities in Amroha, Uttar Pradesh. According to the manuscript's descriptive findings, community involvement is more prevalent in familiar, casual, and culturally entrenched activities than in organized group activities or volunteer work. While involvement in school, youth, or other organized group activities was somewhat low, helping neighbors and attending religious, cultural, or festival events were reported to be relatively regular. This trend implies that current community practices could serve as useful starting points for locally pertinent mental health awareness initiatives.

According to the social-connectedness data presented in the manuscript, a large number of respondents feel at ease in their village and perceive support from friends and family. However, the answers about loneliness, feeling like an outsider, having someone to talk to when anxious, and feeling that community members care about one another suggest that not everyone experiences social support in the same way. These results highlight an important distinction: social networks and involvement in communal life do not ensure that everyone feels understood, included, or able to talk about emotional challenges. Therefore, community efforts should take into account social ties' quality, safety, and inclusivity in addition to attendance and involvement.

The sample's self-reported well-being may vary, as seen by the stated mean WHO-5 score of 57.5 out of 100. Less than half of respondents reported feeling happy and in good spirits most or all the time, and the item-level summary shows that waking up feeling relaxed and fresh is a relatively weaker region. It is important to exercise caution when interpreting these descriptive patterns. The WHO-5 does not establish a clinical diagnosis or identify the reason behind a person's well-being score; instead, it measures self-reported well-being over the previous two weeks. Sleep, physical health, work demands, family duties, economic conditions, and other environmental factors might potentially be important, although evaluating these possibilities would require more information.

Additionally, the paper indicates reduced agreement with two statements related to stigma and higher post-participation mean scores on positively phrased mental health knowledge and help-seeking questions. Knowing where to get help and identifying symptoms of mental distress are the two areas with the biggest reported changes. These numbers might show a positive shift in participants' awareness and attitudes if they are based on matched responses gathered before to and following Mansarthi activities. However, the publication should indicate whether the same respondents were compared, how many of the 85 participants completed both evaluations, and whether baseline responses were gathered prior to the activities or recalled later. Instead of providing conclusive proof that Mansarthi was the source of the alterations, the results should be characterized as documented pre-post differences in the absence of this information.

According to the study's conceptual framework, perceived social connectivity may be one pathway linked to well-being, and community engagement may offer chances for communication and information exchange. This is in line with research that examines the importance of social connections and support for mental health (Holt-Lunstad et al., 2010; Kawachi & Berkman, 2001). However, a statistical relationship between community participation, connection, and WHO-5 scores cannot be established by the descriptive statistics in the current publication alone. The author should present the pertinent correlation or group-comparison findings using participant-level data, along with sample sizes and pertinent statistical information, in order to support this portion of the research question. It is not appropriate to interpret the results as proving causation.

The results are useful for promoting mental health in rural areas. Accessible and culturally sensitive methods of introducing mental health information may be facilitated by familiar community settings and reliable local connections. However, professional treatment cannot be replaced by awareness. People's ability to take action on the information they get may be impacted by stigma, confidentiality issues, cost, distance, and the availability of qualified providers. Therefore, Mansarthi and similar programs might be most helpful when awareness-raising is linked to trustworthy information about nearby services and unambiguous referral options, while maintaining participant privacy and avoiding the presentation of community volunteers as stand-ins for licensed mental health professionals.

7 CONCLUSION

In some rural settlements in Amroha, Uttar Pradesh, this study examines the connection between self-reported mental well-being, social connectivity, and community participation while taking Mansarthi's mental health awareness and attitudes into account. According to the manuscript's descriptive findings, engagement is most evident in routine communal activities like lending a hand to neighbors and attending religious or cultural events. While some replies indicate loneliness, exclusion, or difficulty finding someone with whom to share emotional difficulties, many respondents also report feeling comfortable in their community and receiving assistance from friends and relatives.

After engaging in Mansarthi exercises, the manuscript also finds improvements in a number of mental health awareness and help-seeking attitude items. Although these findings are encouraging, they should be regarded as preliminary until the matched sample and pre-post data collection procedure are clarified and the numbers are compared to the original surveys. Similarly, before any correlation between community participation, social connectivity, and well-being can be verified, participant-level data must be analysed.

Overall, the study emphasizes how important it is to look at rural mental health via both ongoing obstacles and community strengths. Local awareness initiatives and community networks may provide helpful platforms for talking about mental health and addressing myths, but they should be connected to appropriate, confidential, and easily accessible professional assistance. As long as the study's conclusions stay in line with the evidence and as long as subsequent evaluations improve the evaluation of results, it can help promote context-sensitive mental health in rural areas.

Recommendations

- **Increase awareness in familiar neighbourhood contexts**. Expand on current community events and reliable local networks to disseminate age-appropriate, understandable information about mental health, typical symptoms of distress, and how to get help.
- **Provide inclusive, safe spaces for conversation.** Make use of small-group conversations and activities that allow residents who are less connected, women, youth, and older persons to engage without feeling pressured. Ensure anonymity and make participation voluntary.
- **Clearly explain the support services available.** Create and maintain a verified list of local public health facilities, licensed counsellors, helplines, and referral routes. Describe how professional evaluation or treatment cannot be replaced by awareness-raising activities.

- **Analyse operations in a methodical manner.** Whenever possible, use the same participants and precisely recorded time periods to get baseline responses prior to an activity and follow-up responses following it. Keep non-identifying records of attendance, participant comments, and recommendations.
- **Adapt delivery to literacy and age.** When necessary, offer impartial support while using straightforward language and meticulously translated content. Obtain the necessary ethics approval, parental or guardian agreement, child assent, and adhere to safeguarding measures because the specified sample comprises participants aged 6–17. Verify that the measurements are appropriate for the specified age groups.
- **Address problems that go beyond awareness.** Participants should be questioned regarding stigma, service availability, distance, cost, and confidentiality. Utilize these results to inform sensible referral agreements and cooperation with local agencies and experienced medical specialists.
- **Conduct a more detailed follow-up investigation.** A larger and more precisely defined sample, open sampling practices, a recorded description of the intervention, follow-up measurements, and, if practical, a comparison group might all be included in future studies. This would make it easier to differentiate between short-term shifts in consciousness and long-term shifts in wellbeing.

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