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SANITATION AND HYGIENE AMONG WOMEN IN RURAL MURSHIDABAD: AN INTERSECTIONAL ANALYSIS

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ABSTRACT

Intersectional analysis reflects gaps persisting in the access to sanitization and hygiene, as accessed by women. Women from rural areas in Murshidabad are compelled to face discriminations, taunts, mocking, stigmas while accessing community toilet and water resources. Whereas women from upper classes are affording well-facilitated toilets, water supply among others. These gaps and disparities increase health risks, which needs to be reduced. Moreover, they are burdened with the household works, leaving no time for education or employment. Need of the hour is education, which would make them aware about the clean and safe hygiene practices to avail for a healthy lifestyle.

Key words: Sanitization, hygiene, women, rural areas, Murshidabad, intersection, analysis

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1. INTRODUCTION

This paper conducts an intersectional analysis of sanitation and hygiene practices, barriers and challenges persisting among women in rural Murshidabad (West Bengal, India). For this analysis, social factors (gender, caste, class, religion, age), shaping access to sanitation services, hygiene practices, and health outcomes are considered (Shekhar & Dwivedi, 2024). At the initial stage, context is set for drawing concrete attention of the readers to the research topic.

Sanitation infrastructure, in rural Murshidabad, has witnessed significant improvements. Total coverage through sanitation, is approximately *69.7%* of the total households. This is according to the NFHS-5 data gathered for West Bengal. As per the critics, the percentile is slightly above the state average. It is still a concern that significant gaps persist in the hygiene practices, access. One of the positive aspects is the construction of toilets by Swachh Bharat Mission (Grameen) and allied programs in the district. However, the positivity is reduced with references to improper functioning, poor maintenance, improper access (Mitra & Rao, 2019). Evidence lies in poor behavior change, irregular water availability, and socioeconomic constraints. All these aspect limit sanitation usages.

2. LITERATURE REVIEW

2.1 Gender based discriminations in Sanitation and Hygiene

Women's roles have been vulnerable, since ages, in terms of using water, sanitation, and household hygiene. This has been observed in the rural areas. The women are held responsible for using water the most, for fetching water, cleaning, caregiving, and child sanitation. However, they encounter disparities in accessing clean and safe drinking water in fulfilling these tasks. Poor access increases health risks for these women. Evidences lies in risks of urinary and reproductive tract infections, hygiene-related morbidities among others. It is striking to note that lack of toilets compels women to defecate in open. As a result of this, they are exposed to shame, taunt, mocking harassment and risks by men during early morning or late hours. Most of the time, as Chakraborty, and Satapathy, (2024) stated, for these women, is spent in time collecting water, managing sanitation needs, household chores. Immediate impact is adverse affectation in education, livelihoods, and lifestyle.

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2.2 Menstrual Hygiene Management (MHM)

Limitations are there in specific data on menstrual hygiene management for Murshidabad. Broader conditions in West Bengal and similar rural contexts reveal that significant proportion of rural women are in need of adequate menstrual hygiene products and awareness. The initiatives undertaken for enhancing this awareness enhanced taboos, misguiding the women on adopting safe practices. As a result of this, they have been seen to use old cloth, ash to clean themselves. This is really unsafe, increasing the risk of diseases. Here, Dhawan and Donner, (2025) argued that even if there are toilets or safe hygiene practices, privacy, water access, and disposal mechanisms are not up to date. As a result of this, adolescent girls and women with low education, coming from poorer strata of society hesitate to use them.

2.3 Intersection between social identities and experiences

2.3.1 Caste and Class

An intersectional approach to the discussion yields lack of homogeneity in the women's access to sanitation. Evidence lies in the lack of access to household toilets for women from Scheduled Castes (SC), Scheduled Tribes (ST), and Other Backward Classes (OBC). For this lack, they are exposed to discriminations, when they attempt to access community water sources or toilets. On the contrary, wealthier households afford private toilets and piped water. This gap reflects struggle among poorer families in terms of shared or unimproved sanitation. This implies that caste acts as a barrier for women, when they access basic resource for fulfilling their needs. For example, Kannabiran and Swaminathan, (2017) stated that if a woman from OBC community accesses toilets for generals, they are exposed to multiple layers of discriminations as compared to a woman from an upper class or caste.

2.3.2 Religion and Social Norms

In Murshidabad, diversity lies in religious influences on sanitation norms and practices. According to social and cultural norms, every woman should be pure, and not discuss about pollution, sanitation, menstrual hygiene, and latrine use, whenever they feel like. Sarkar, (2016) was of the view that taboos, stereotypical notions, stigmas around menstruation and gendered mobility limits women's ability to use public facilities safely and with dignity.

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2.3.3 Age and Life Stage

Adolescent girls in rural Murshidabad are particularly vulnerable, as they lack proper hygiene products. Along with this, they are also unaware about safe, private sanitation, due to which parents do not send these girls to schools. Immediate impact is absenteeism and dropouts. Younger members of the family have less bargaining power, for which the bigger ones especially the males do not think of prioritizing sanitation investments. On the other hand, Hassan, (2018) argued that older women are more prone to long-term health impacts due to poor water, sanitation, hygiene exposure.

2.4. Structural and Policy Dimensions

Government programs like Swachh Bharat Mission (Grameen) has expanded the access dynamics to toilets and sanitation for women. However, often emphasis lies on construction of sustaining behavioral change. Mention can be made of Jal Jeevan Mission and community institutions (e.g., Village Water & Sanitation Committees), who are initiating women involvement into the programs of improving WASH governance. Despite these initiatives, gaps persist in the stage of implementation. Women's decision is not that significantly dealt, as their contribution in decision making remains nominal. Women from the higher classes are preferred. Inconsistency is reflected in the maintenance of toilet facilities, water reliability, and hygiene supplies. Policy responses are also ineffective, as they frequently overlook intersectional barriers especially caste discrimination, disability, religion, age). According to Lorea, (2020), this carelessness leads to uneven benefits across groups.

2.5 Poor Sanitation and Hygiene carrying adverse impacts

Health consequences are dire when women are exposed to poor sanitization and hygiene practices. Dirty toilets cause infections among women. In phases of menstruation, unclean toilets, improper hygiene and unsafe water is seriously risky for women, especially the ones in rural areas. When it comes to education, girls from the rural areas do not attend schools during their menstruation period. As the girls and women are compelled to do the household works, sanitization, there is no time left for pursuing education, employment, or community engagements. The women are not deliberately using unclean toilets. They are made to do so, where their caste, class, gender is a curse. Shekhar and Dwivedi, (2024) were of the view that this becomes an issue, concern,

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undermining women's dignity and autonomy, affirming gendered constraints on their mobility and decision-making.

3. METHODOLOGY

Deductive approach is effective for deducing the notions, facts, ideas, theories and concerns related to sanitization and hygiene for rural women in the threshold of Murshidabad, west Bengal. This deduction can be sketched from the survey responses drawn from 100 such women from a rural area. This evokes quantitative data collection method, survey, which provides practical experience on the barriers, issues, concerns and challenges for them in sanitization and hygiene practices. Tables, charts, graphs add to the analysis of responses which has been gathered through surveys.

4. CONCLUSION

Sanitization and hygiene practices for women in rural areas of Murshidabad are poor. Evidences are the stigmas, taunts, mocking, discrimination, to which these women are exposed, while accessing community toilet facilities, water resources, among others. Adolescent girls lack adequate education on clean, safe and accessible practices during menstruation. As a result of this they miss schools, which affects their academic life. Women from poor backgrounds hesitate to use the toilets and still rely on old clothes and ash to clean themselves. Consistency in this context increases their health issues and risks. Here, government is to strive for extending beyond the infrastructural plans for altering the behavior of the rural women. Here, concerns on health worsening, water supply reliability, menstrual hygiene support, and safe disposal systems are to be communicated properly to the women and girls, especially to the ones who are marginalized. It is to be ensured that policies framed, reach women, properly, especially to the ones from SC/ST and low-income households. Affirmative WASH financing and inclusive governance can be undertaken by empowering women. This empowerment can be caused by involving women from diverse groups and cultures into Village Water & Sanitation Committees and Gram Panchayats. Along with this, integrating gender-sensitive and culturally informed education programs on sanitation and menstrual health will reduce the cultural barriers. Consistent efforts are needed for collecting and using disaggregated data. This could be done with the consideration of caste, class, age, religion, which will be effective for tracking progress and tailor interventions.

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