Journal of Advances and Scholarly Researches in Allied Education
Vol. 17, Issue No. 2, October-2020, ISSN 2230-7540

A Study on Rural Women's Extent of Participation in Sanitation

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Abstract -More female participation was acknowledged by the development community to be essential to achieving the goal of sanitation for everyone during the International Drinking Water Supply and Sanitation Decade (1981–90). The United Nations system and bilateral organisations have started new projects aimed at women in an effort to increase their participation in the development of water supply and sanitation services. Water, sanitation, and health are often women's responsibilities. As women have traditionally been the ones who collect water, teach cleanliness to children, and understand the health consequences of unsanitary living conditions, they have always held a disproportionate amount of environmental knowledge. Unlike males, who are seldom forced to go large distances to gather water, women and girls are disproportionately asked to do so (WGTF, 2006). As a result, this study has made a serious effort to inquire into the worth of women's participation in sanitation-related efforts.

Keywords - Sanitation, Women, Rural women, Participation

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INTRODUCTION

In the absence of home or neighbourhood toilet facilities, women in rural India, like in other areas of the globe, typically face a lack of privacy, harassment, and the necessity to trek long distances to locate a suitable site for defection. Some people are known to avoid going outside during the day if they have a urinary tract infection, while others may wait until the early morning or late at night to do so. The effects of public humiliation, particularly during menstruation, on a woman's sense of self-worth and dignity are far-reaching and have important implications for girls' educational participation and enrollment. Studies show that lack of access to secure, private toilet facilities substantially increases absenteeism among female students and contributes to their dropping out of school altogether.

Lack of access to sanitary facilities and clean water disproportionately affects women and girls because of their greater desire for privacy when defecating and washing than males. In places with poor sanitation, women are disproportionately likely to have health problems related to poor hygiene practises, such as faecal-oral transmitted diseases, uro-genital tract infections, urinary incontinence, and chronic constipation. As women are less likely to be shamed if they defecate in private during the day, they may eat less and become underweight if they do so. Lack of access to adequate sanitary facilities is a major contributor to stress, harassment, and sexual abuse, as well as to the burden of doing unnecessary tasks such as transporting water, caring for the ill and old, and cleaning up after faeces. It is considered that if adequate water, sanitation, and hygiene services were made available, these detrimental impacts might be mitigated and their quality of life enhanced. It was estimated that in 2012, 1.25 billion women, or one-third of all women, lacked access to proper sanitation (Sharma, 2009). Around 526,000,000 of these individuals lacked access to toilets and hence had to defecate in the open.

In low-income areas, women and girls are frequently the ones in charge of water and sanitation services since they are the primary users, providers, and administrators of these amenities. Being the traditional gatekeepers of domestic sanitation, their inclusion in sanitation programmes is considered as a viable long-term solution. Female participation in decision-making on water sources, financial transparency, and the management of sanitary measures have all been associated to programme effectiveness (Ventha, 2000). Research conducted in Kenya indicated that better sanitation might be achieved if women had a larger voice in key household expenditures. Now that the importance of women's involvement in the water and sanitation sector has been established, development programmes have begun to reflect this (Tremolet, et al., 2010).

In recent years, policies have increasingly emphasised the need of include 'women' in cleanliness efforts. Certain African countries, from the ministerial level down to the village level,

require a certain percentage of women to be included in sanitation programmes and related decision making. The water and sanitation organisations Total Sanitation Campaign (TSC), Nirmal Bharat Abhiyan (Clean India Campaign—NBA), and Swachh Bharat Abhiyan (Clean India Mission—SBA) have all reserved 33 percent of their membership for women in an effort to close the gender gap.

Nevertheless, in practise, field-level promoters seldom actively encourage women's participation. Deliberate initiatives to increase women's participation in water and sanitation committees have been shown to be effective, however this is not always the case. There has not been an increase in the number of women who participate in community-level decision making as a consequence of women's participation in meetings to promote and raise awareness of the need for cleanliness. Women's involvement in sanitation decision making is hindered by factors like societal and cultural constraints, their age, and their status within the family. Men were found to be more likely than women to make the choice about whether or not their household had access to a latrine in a worldwide evaluation of data on the determinants of latrine ownership in rural settings (Hazra, 2013). Although though everyone in the household had the right to use the toilet, one study found that just one in four male household leaders in Ghana really took the decision to adopt. Researchers in India found that although males often make the choice to acquire a latrine, it is typically the women in the home who are responsible for its upkeep and maintenance, as well as the provision of the flushing water. Despite their lack of interest, some male chiefs would nevertheless go out and buy latrines for their new daughters-in-law so that they may have some privacy and maintain their perceived status. Research has also found that men are less likely to take the effort to construct or use a toilet if one is not available. This might lead to fewer individuals using latrines, since men are less likely to prioritise sanitation than women (Rosensweig, et al., 2012).

Women's agency in shaping their own lives has been the subject of a plethora of research, particularly as it relates to issues of health, fertility, and well-being. There has been a lot of research done on the mental, financial, social, and environmental elements that all play a role in improving sanitation. Studies have shown that behavioural elements such as preference, intention, and choice phases contribute to family sanitation decision making despite the fact that cost is generally mentioned as the key reason for not building latrines. Yet, contrary evidence to this pricing claim has been revealed in a recent research of rural Indians. The research found that people don't defecate in the open because they can't afford latrines, but rather because they think latrines are too expensive (Robinson, 2010). Little research has been conducted on the topic of women's agency, engagement, and possible impact on latrine adoption as part of larger family initiatives to enhance sanitation (Sanan, and Moulik, 2007).

They prefer the quiet of the early morning or the cover of darkness if they have a health problem, such a urinary tract infection, that prevents them from going out during the day. Women's dignity and sense of value are undermined when they are exposed in public, especially during menstruation, which has serious consequences for girls' school attendance and enrollment. Women are more likely to drop out of school if they don't have access to safe, clean restrooms.

RESEARCH METHODOLOGY

Design of the study

The current study incorporates both qualitative and quantitative research elements. The quantitative data-analysis approach has been employed with the aid of the appropriate statistical methods to analyse the replies in relation to the research's first goal, which was to assess the degree of knowledge about the fundamental sanitation practises among rural women. In order to simultaneously determine the outcomes for the other four (4) goals, a thorough analysis of the obtained replies was carried out, displaying the characteristics of a qualitative analysis. Hence, the character of this research is both qualitative and quantitative.

Sources of data

Primary Sources Information was gathered via focus groups and interviews (FGDs). Secondary Sources Information were gathered from books, research reports, journals, articles, official documents in the form of brochures, booklets, and working papers, newspaper clippings, and other printed, electronic, and web-based resources that are readily accessible.

Sampling procedure

For this investigation, a multi-stage cluster sampling methodology has been used.

The following phase involves the random selection of two (2) Gram Panchayats (GPs) from each of the specified blocks.

Thereafter, two (2) villages have been randomly chosen from each of the chosen gramme panchayats.

In the end, fifty (50) randomly picked houses from each of these chosen villages were taken into account, and ultimately, from all of the 600 households, a sample of 300 women respondents were chosen and interviewed to provide the

necessary data for this research. These 300 women were regarded as the study's main responders. The methodology for choosing the key responders is examined in Diagram 1 (which appeared on the next page).

Tools and procedure of data collection

- Interview Schedule:
- Focused Group Discussion(FGD):

Procedure of data analysis

After obtaining all essential and comprehensive replies and opinions from the respondents as well as the informants, taking into account the various research goals, both qualitative and quantitative analyses of the data were performed in this study. To ensure the correctness of data analysis, quantitative data have been examined using SPSS (Statistical Program for the Social Sciences) software.

DATA ANALYSIS AND INTERPRETATION

- **Rural women level of awareness about basic sanitation practices**

The following analysis and interpretation have been performed based on the data obtained, bearing in mind the primary purpose of this research, which is to investigate the degree of knowledge among rural women regarding fundamental sanitation practises, and they are as follows:

The 'F' ratio was calculated to see whether there were statistically significant variations in the level of awareness about basic sanitation practises among the women in the three blocks of the district of Madhya Pradesh (Table 1). After comparing the calculated "F" value to the pivotal value in the table, it was found that the calculated value (.417) was not greater than the table value (3.03 & 4.68 at 0.05 and 0.01 level of significance). This leads the researcher to infer that there are no significant variations in the level of understanding of basic sanitation practises among women living in the three selected blocks of the District. So, it is safe to assume that the women in all three buildings have a same understanding of hygienic best practises.

Table 1: Synopsis of the 'F' test (analysis of variance): Gender differences in knowledge of fundamental hygiene procedures (Block-wise)

Name of the Blocks	N	Mean	Std. Deviation	Std. Error
Bhind	100	132.11	11.996	1.200
Satna	100	132.70	9.229	.923
Sagar	100	133.54	11.954	1.195
Total	300	132.78	11.113	.642

Table 2: ANOVA about the basic sanitation practices among Women (Block-wise)

Source of variations	Sum of Squares	Df	Mean Square	F	Sig.	Remarks
Between Groups	103.287	2	51.643	.417	.660	Not significant
Within Groups	36825.630	297	123.992			
Total	36928.917	299				

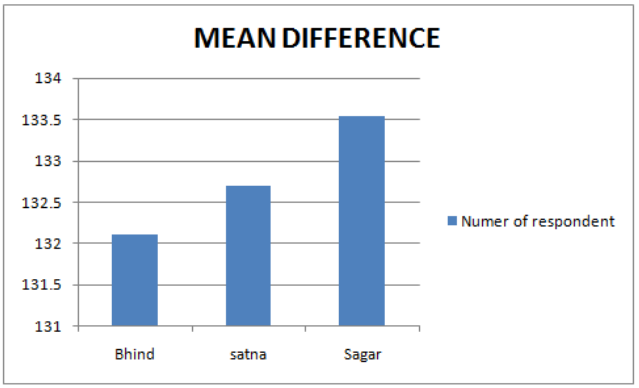

Figure 1: Mean Difference(Block Wise)

In order to determine if there is a substantial difference between women with elementary and high school education and those who are illiterate in terms of their understanding of fundamental sanitation procedures, the "F" ratio was determined (Table, Figure). By comparing the computed "F" value (2.094) to the pivotal value in the table, it was found that the computed value did not exceed the table value (3.03 & 4.68 at 0.05 and 0.01 level of significance). The study's findings indicate that college-educated women and low-income women have similar levels of situational awareness about essential sanitation practises. So, it may be concluded that women of all three educational levels have a common understanding of basic hygiene practises.

Table 3: Summary of 'F' test (ANOVA): Difference in the level of awareness about the basic sanitation practices among Women (Educational Status-wise)

Educational Level	N	Mean	Std. Deviation	Std. Error
Illiterate	70	131.94	9.776	1.168
Primary	118	131.68	11.234	1.034
HSC	112	134.47	11.646	1.100
Total	300	132.78	11.113	.642

Table 4: ANOVA of basic sanitation practices among Women (Educational Status-wise)

Source of variations	Sum of Squares	Df	Mean Square	F	Sig.	Remarks
Between Groups	513.463	2	256.731	2.094	.125	Not significant
Within Groups	36415.454	297	122.611			
Total	36928.917	299				

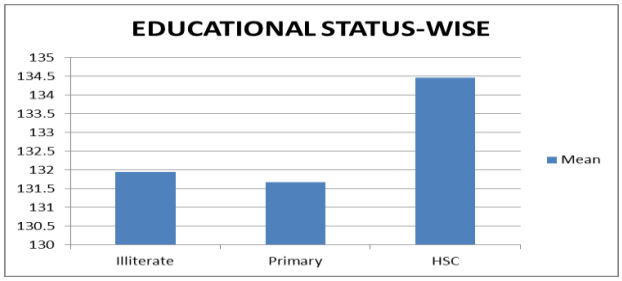

Figure 2: Mean Difference (Educational Status-Wise)

To compare the sanitation knowledge of women from APL and BPL households, we used a t-test (Table, Figure) to compare the means and standard deviations of these women. The t value of.743 is not statistically significant at the 0.05 or 0.01 levels. The mean value for women in APL and BPL listed families is same, as seen in the table and the figure. Hence, it may be inferred that the degree of understanding of basic sanitation practises among women from APL and BPL homes is not significantly different.

Table 5:'t'-Test Result: Difference in the level of awareness about the basic sanitation practices (Family Economy-wise)

Variations		N	Mean	SD	't'	Remarks
Economic Status of the Family	APL	177	133.18	11.889	.743	Not significant
	BPL	123	132.21	9.910		

df =298at0.05level't'value:1.97

0.01level't'value:2.59

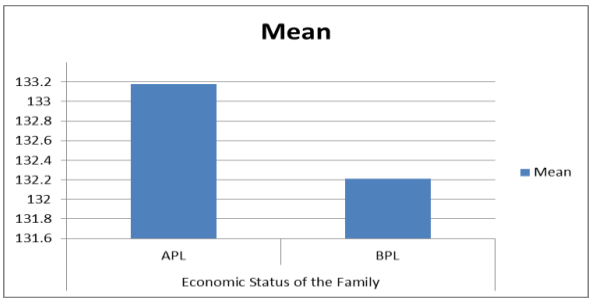

Figure 3: Comparison of level of awareness about the basic sanitation practices between Women belonging to APL and BPL Families

Prevalence Of Diseases Among Women As A Consequence Of Not Using Sanitary Latrine

To calculate the percentage of women who use tampons and other menstrual products, we surveyed 300 women from 300 different households and obtained the necessary data. After looking at the numbers, researchers found that 45.66 percent of the sample population still relies on open defecation while 54.33 percent of women utilise improved sanitation facilities such latrines (Table and Figure).

Table 6: Usage of Sanitary Latrine among Selected Women

Total Household surveyed	300	100%
Women Using Sanitary Latrine	163	54.33%
Women Practicing Open Defecation	137	45.66%

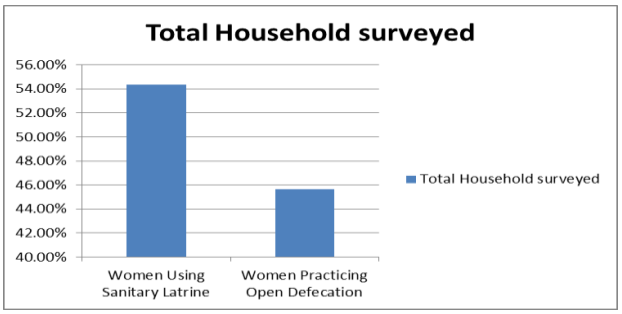

Figure 4: Usage of Sanitary Latrine among Selected Women

Additional investigation finds that 66 women, or 48.17 percent, of all women who engage in open defecation have been diagnosed with "soil transmitted illnesses" (such as hookworm infections), whereas 71 women, or 51.82 percent, have never been sickened by the practise. The purpose of collecting this data is to assess the rate of illness incidence among women during the last two years (Table and Figure).

Role Of Women In Promotion And Management Of Rural Sanitation

To accomplish the third goal of the study, which was to investigate the part played by women in the promotion and management of rural sanitation, especially at the household level, three (3) Focus Group Discussions (FGDs) were held with randomly selected 150 women (1 woman per household), taking 50 women from each of the three (3) selected blocks. Parallel focus group discussions (FGDs) consisted of three (3). The following tables, based on six FGDs with a total of 150 female and male participants, show the replies from both groups of respondents with respect to women's role in promoting and managing sanitation, especially at the home level:

Table 7: FGD Session–1:Conducted 50 Women (randomly chosen from the sample) of Satna Block

• Women and girls used to collect drinking water for their families. • Mothers used to provide tampons and diapers for their children. • Women and girls used to raise awareness among other family members, particularly children, about the significance of using safe drinking water by citing examples of the adverse effects of various water-borne diseases. • Women and girls used to collect drinking water for their families. • Women and girls used to train children regarding basic sanitary practises such as washing hands before taking food, not taking uncovered food, taking baths.

Table 8: FGDSession–2: Conducted among 50 Male members from the same households of Satna Block

• Women used to keep the houses clean
• Basically female members of the family used to clean the sanitary latrine as well as household toilets
• Used to teach children to wash their hands before having food and after defecating
• Used to ensure proper drainage facilities by cleaning the garbage
• They used to carry the drinking water from the nearest available drinking water source
• They used to teach children to wash their hands before having food and after defecating

CONCLUSION

The author of the research comes to the conclusion that, of all the factors considered, improved sanitation has the greatest impact on the lives of women, especially low-income rural women. Poorly paid women in rural Birbhum often have to decide between using the public restroom in line or leaving their waste outside (constructed by Gram Panchayat). Some women are thus forced into the embarrassing situation of having to urinate in public, where they are more susceptible to sexual attack.

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