



Sanitation-related psychosocial stress: A grounded theory study of women across the life-course in Odisha, India

Krushna Chandra Sahoo ^{a,1}, Kristyna R.S. Hulland ^{b,1}, Bethany A. Caruso ^c, Rojalin Swain ^a, Matthew C. Freeman ^d, Pinaki Panigrahi ^e, Robert Dreibelbis ^{f,*}

^a Asian Institute of Public Health, Bhubaneswar, India

^b Center for Global Health, University of Chicago, Chicago, IL, USA

^c Department of Behavioral Science and Health Education and Center for Global Safe Water/Hubert Department of Global Health, Rollins School of Public Health, Emory University, Atlanta, GA, USA

^d Department of Environmental Health, Rollins School of Public Health, Emory University, Atlanta, GA, USA

^e Epidemiology and Pediatrics and Center for Global Health and Development, College of Public Health, University of Nebraska Medical Center, Omaha, NE, USA

^f Center for Applied Social Research, Civil Engineering and Environmental Science, and Department of Anthropology, University of Oklahoma, Norman, OK, USA

ARTICLE INFO

Article history:

Received 12 December 2014

Received in revised form

17 June 2015

Accepted 22 June 2015

Available online 27 June 2015

Keywords:

Sanitation

Women

Gender

Psychosocial stress

Open defecation

Sexual violence

India

ABSTRACT

While sanitation interventions have focused primarily on child health, women's unique health risks from inadequate sanitation are gaining recognition as a priority issue. This study examines the range of sanitation-related psychosocial stressors during routine sanitation practices in Odisha, India. Between August 2013 and March 2014, we conducted in-depth interviews with 56 women in four life stages: adolescent, newly married, pregnant and established adult women in three settings: urban slums, rural villages and indigenous villages. Using a grounded theory approach, the study team transcribed, translated, coded and discussed interviews using detailed analytic memos to identify and characterize stressors at each life stage and study site. We found that sanitation practices encompassed more than defecation and urination and included carrying water, washing, bathing, menstrual management, and changing clothes. During the course of these activities, women encountered three broad types of stressors—environmental, social, and sexual—the intensity of which were modified by the woman's life stage, living environment, and access to sanitation facilities. Environmental barriers, social factors and fears of sexual violence all contributed to sanitation-related psychosocial stress. Though women responded with small changes to sanitation practices, they were unable to significantly modify their circumstances, notably by achieving adequate privacy for sanitation-related behaviors. A better understanding of the range of causes of stress and adaptive behaviors is needed to inform context-specific, gender-sensitive sanitation interventions.

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1. Introduction

Despite 15 years of concerted efforts under the framework established by the Millennium Development Goals (MDGs), the global sanitation crisis persists. Over 2.5 billion people still lack access to improved sanitation facilities, and 1 billion people

* Corresponding author. Center for Applied Social Research, 201 Stephenson Parkway, Suite 4100, Norman, OK 73019, USA.

E-mail address: rdreibe@ou.edu (R. Dreibelbis).

¹ These authors contributed equally to the work.

practice open defecation (OD) in fields, bushes, or other open spaces (WHO and UNICEF, 2014). Although global sanitation targets under the MDGs are included in the environmental sustainability goals (Goal 7), a key reason for increasing sanitation coverage is to reduce exposure to human fecal pathogens, reducing enteric disease burden among children under five (Ahmed et al., 2012; Cairncross et al., 2010; Wolf et al., 2014) and improving child growth and development (Dangour et al., 2013; Spears et al., 2013).

In India, two-thirds of the population lives with unimproved sanitation and an estimated 600 million people defecate outside, representing 60% of the global population practicing OD (WHO and UNICEF, 2014). In rural northern India, Coffey and colleagues

describe local perceptions that open defecation is a long-standing habit, more comfortable, and provides an opportunity to “take in the fresh air” (Coffey et al., 2014, 53).

To increase sanitation coverage, India launched the Total Sanitation Campaign (TSC) in 1999 to accelerate rural sanitation development and achieve universal access to latrines by 2012. However, TSC has made only modest gains in latrine coverage (Patil et al., 2014). Though TSC incorporated financing incentives for households below poverty level and aimed to be user- and community-driven, the campaign has been critiqued for being a top-down intervention highly focused on infrastructure development. Even with increased latrine coverage, latrine use remains low, in part due to poor or incomplete construction (Boisson et al., 2014; Clasen et al., 2014). Women have been targeted as key stakeholders for the success of TSC; however, after achieving “total” sanitation coverage, many women stop participating in on-going educational meetings in their communities.

While recent policy discussions on sanitation have focused on health impacts among children under five years of age, there is growing recognition of the unique health risks women and girls face due to inadequate sanitation, including increased maternal mortality risk from unhygienic birthing practices and poor infection control (Cheng et al., 2012); uro-genital tract infections (Mudey et al., 2010) and urinary incontinence and chronic constipation (Fisher, 2006). Additionally, insufficient access to basic water and sanitation resources has been linked with psychosocial stress in other low- and middle-income countries, for example Ethiopia and Bolivia (Stevenson et al., 2012; Wutich and Ragsdale, 2008), as well as with increased risk and fear of violence in schools in South Africa (Abrahams et al., 2006), and risk of sexual violence in the slums of Delhi, India (Lennon, 2011) and Kampala, Uganda (Massey, 2011). An emerging trend toward gender-responsive sanitation approaches emphasizes the physical, social, and environmental needs of women (Tilley et al., 2013), increasing demand for gender disaggregated data (UN, 2008) and gender-sensitive programming to improve equity and dignity (de Lange, 2013; Diczfalusy, 1997; Gender and Water Alliance & UNDP, 2006). Recognizing the intimate connection between the sanitation environment and the physical and mental wellbeing of women and girls underscores the need for a contextualized understanding of sanitation-related psychosocial stress in countries where adequate sanitation facilities are lacking.

This study aims to further understanding of the psychological, social, and health impacts of sanitation routines among women of reproductive age in three distinct socio-geographic settings in Odisha, India: urban slums, rural villages and indigenous villages. Predicated on the assumption that women’s lives and their sanitation needs and experiences are not static across the reproductive period, we adopt a life course perspective, with the life course defined as the “sequence of socially defined events and roles that the individual enacts over time” (Giele and Elder, 1998, 22). Taking a life course approach allows us to examine the influence of age, context and social processes on a woman’s experience and family life and how those factors collectively impact the experience of sanitation.

2. Methods

We utilized principles of Grounded Theory in conducting this research (Charmaz, 2014). Sample selection, data collection, and analysis were done in an iterative, mutually informed process so as to be responsive to emergent themes and concepts. In Grounded Theory, findings are identified inductively through data collection and analysis rather than guided by an existing theoretical model.

2.1. Field sites

This study was conducted in Odisha, India, a state with a total population of 41 million, approximately 85% living in rural areas. Odisha lags behind other states in improvements in sanitation facilities: 78% of the population practices OD with significant disparities between urban (41% OD) and rural (88% OD) areas (Census Organization of India, 2011). This represents a higher proportion of open defecators compared to national averages (50% OD; 12% OD urban, 65% OD rural) (WHO and UNICEF, 2014).

We identified three distinct socio-geographic settings in Odisha: urban slums, rural villages and indigenous (“tribal” in emic terms) villages. These categories reflect typical resource-poor, infrastructure-restricted settings in South Asia while offering an opportunity to examine how variations in social organization, the physical and built environment, and cultural practices shaped women’s sanitation experiences. First, our sample included three urban slums in Bhubaneswar, the capital of Odisha. Bhubaneswar has an average population density of 2134 people per square kilometer and over 300 recognized slum settlements (Census Organization of India, 2011). Slums selected for this study included one large informal, densely populated slum with privately operated communal latrines and two government-authorized slum communities with limited access to government-supplied water and electricity. Private latrines were rare in all urban communities included in our study. Next, rural sites were selected from Khurda district, a predominantly agrarian region with a population density of approximately 800 people per square kilometer. Lastly, indigenous sites were selected from Sundargarh District, which has a population density of 216 per square kilometer. Over 50% of the population in Sundargarh District belongs to one of India’s Scheduled Tribes (*Adi-wasis*), ethnically distinct indigenous groups with recognized status by the Indian government, including predominately Oraron, Munda, and Kisan tribes (Census Organization of India, 2011). Women in these tribal communities were expected to have markedly different sanitation challenges than other women in our sample: population density is much lower than in other sites, many indigenous groups are matrilineal, gender roles are less defined, and more women take part in the labor force. Scheduled Tribes have also been historically marginalized by the mainstream population (Mitra, 2008). Migration and urban growth, particularly in relation to the steel industry, have increased ethnic diversity in Sundargarh District in recent years; however, the region remains relatively isolated from existing transportation and telecommunication networks. For the purposes of this study, we use the term “indigenous” to refer to women living in this tribal region.

2.2. Sample and participants selection

Data collection sites in each geographic setting were selected based on existing Asian Institute of Public Health (AIPH) partnerships or programs; specifically we selected regions where community health volunteer programs focusing on maternal and child health had been established or were under development. We identified participants from four “life stages”: adolescent girls, newly married women, pregnant women, and established adult women. Adolescent girls included unmarried women below the age of 25 who had reached menarche. Women in this group typically lived at home with their parents and extended families. Newly married women were defined as being married for less than two years. Exogenous patrilocal residence, in which the woman moves in with her new husband’s family, is common in this study population, introducing a woman to a new social and physical geography upon marriage. Pregnant women were included as a separate group due to the physical changes of pregnancy and associated changes of

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