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No relief: lived experiences of inadequate sanitation access of poor urban women in India*

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ABSTRACT

The provision of sanitation in India has attracted much attention, but research and policies focusing on gender in relation to sanitation often fail to focus on sanitation-related violence against women (VAW). This article focuses on research in Pune (in Maharashtra) and Jaipur (in Rajasthan). It offers evidence of slum-dwelling women's experiences of harassment and violence related to poor or absent sanitation facilities. In addition, it explores the strategies that women adopt to minimise risk and stress. Sanitation-related violence shows the connections between slum geographies and unequal intra-slum relationships of gender, caste, and economic and marital status, and the types of sanitation facilities available. These different identities shape women's experiences of VAW and they commonly blame men from 'outside' or 'other' groups, affecting their ability to act as a united group against violence. While sanitation is inadequate and inappropriate for women's needs across castes, community cohesion and the chances of collective action and advocacy to address sanitation needs are also compromised by tensions between groups in the slum.

Aunque en India el suministro de servicios de saneamiento ha suscitado mucho interés, aquellas investigaciones y políticas centradas en el género, y vinculadas con el tema del saneamiento, no logran hacer frente a la violencia contra las mujeres (VCM) basada en esta cuestión. El presente artículo da cuenta de una investigación realizada en Pune (en Maharastra) y Jaipur (en Rajastán), a partir de la cual se constató la existencia de vivencias de acoso y violencia sufridas por mujeres de los barrios pobres de dichas ciudades por razones que tienen que ver con las inadecuadas instalaciones de saneamiento existentes o su ausencia. Asimismo, examina las estrategias adoptadas por las mujeres para minimizar el riesgo y la tensión en este sentido. La violencia vinculada al saneamiento pone al descubierto las conexiones existentes entre las diversas geografías presentes en los barrios marginales y las relaciones desiguales que se establecen al interior de los mismos por motivos de género, casta, condición económica y estado civil, así como debido a las instalaciones de saneamiento disponibles. Estas identidades diferentes moldean las vivencias de las mujeres en torno a la VCM, ya que frecuentemente estas culpan a los hombres "de fuera" o a "otros" grupos, lo cual afecta su capacidad de actuar unidas contra la misma. Si bien es cierto que el saneamiento es inadecuado y poco apropiado para satisfacer las necesidades de las mujeres de todas las castas, la

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cohesión comunitaria y las posibilidades de realizar acciones conjuntas o de incidencia para reivindicar la realización de mejoras en este se ven comprometidas por las tensiones que se crean entre distintos grupos de estos barrios.

La fourniture d'installations sanitaires en Inde a suscité une grande attention, mais il est rare que les recherches et politiques qui se concentrent sur le genre en rapport avec l'assainissement se concentrent sur la violence à l'égard des femmes (VEF) dans le contexte de l'assainissement. Cet article porte sur des recherches menées à Pune (au Maharashtra) et Jaipur (au Rajasthan). Il propose des données factuelles sur les expériences des femmes vivant dans des bidonvilles en ce qui concerne le harcèlement et la violence liés à des installations sanitaires insuffisantes ou absentes. Il examine par ailleurs les stratégies qu'adoptent les femmes pour réduire au minimum les risques et le stress. La violence liée aux installations sanitaires met en évidence les liens entre les géographies des bidonvilles, et les relations inégales au sein des bidonvilles selon le sexe, la caste, le statut économique et conjugal, et les types d'installations sanitaires disponibles. Ces différentes identités façonnent les expériences de la VEF parmi les femmes, lesquelles en attribuent fréquemment la responsabilité à des hommes venus de l'«extérieur» ou issus d'«autres» groupes, ce qui a une incidence sur leur aptitude à agir en tant que groupe uni contre la violence. Si les installations sanitaires sont insuffisantes et inappropriées pour les besoins des femmes toutes castes confondues, la cohésion communautaire et les chances d'action et de plaidoyer collectifs pour tenter de satisfaire les besoins en matière d'assainissement sont aussi compromises par les tensions entre groupes au sein des bidonvilles.

Introduction

The need for urban sanitation in India is clear. In this article, we seek to unravel the relationship between violence against women (VAW) and sanitation, focusing on its details, specifics, and its impact at different levels, on individuals and society. By analysing the stories of slum-dwelling women, we aim to offer insights into what the absence of sanitation means for women and girls living in poverty in urban India. What emerges is an understanding of both their individual struggles and the unequal relationships that hold India's gendered urban sanitation crisis in place, affecting the ability of some slum communities to take collective action to lobby for solutions.

The article is based on research undertaken between October 2013 and May 2014, in Pune (Maharashtra) and Jaipur (Rajasthan). It involved a number of local non-government organisations (NGOs).[1] The research was undertaken to capture urban poor women's experiences and vulnerabilities due to inadequate sanitation. Our findings offer detailed evidence drawn from observation of real life, on poor urban women's experiences of violence and harassment related to inadequate provision and maintenance of public and community toilets (PTs), and women's continuing use of open defecation (OD) sites as a last resort. The article reveals some of the multitude of coping mechanisms that women have adopted to minimise risk and psychosocial stresses. These tend to operate at the level of the individual and her household. Collective action is shaped by the strong

sense of identity with caste/ethnic/religious groups in the slum, which affects women's experience of VAW itself, as well as their analysis of the roots of the problems they face.

Our primary question as we began our research was, 'If VAW is symptomatic of power inequalities in society, then how do those inequalities manifest themselves in women's psychosocial stress and translate into women's decisions about where to relieve themselves?' Our findings were striking since they show women experiencing sanitation-related psychological stress happening within a context of complex inequalities including gender, class, caste/ethnic/religious, and economic inequalities, which together create social and political disadvantages, 'precarious livelihoods, unemployment, environmental pollution, and more' (McFarlane *et al.* 2014, 9). Intra-household relations, and intra-slum relationships of gender, caste, and marital status, matter deeply for women, and affect their experience of VAW related to inadequate sanitation (Doron and Jeffrey 2014). Simply put, multiple inequalities and slum geographies mattered most for women's experiences of psychosocial stress.

Gendered struggles for safe sanitation spaces

A body of research and policy on gender and sanitation links lack of adequate sanitation in urban slums to insecurity of land tenure, due to the threat of resettlement (McFarlane *et al.* 2014), uncertain access to water (Hirve *et al.* 2015), and poverty/affordability (Kwiringira *et al.* 2014). Constraints on women's access to PTs – commonly seen as the answer in communities where people lack individual household latrines (IHLs) – include physical ability/mobility, distance, route location and condition, facility design, and an insufficient number of toilet stalls. Solutions to lack of sanitation include advocacy for obtaining and maintaining PTs, making IHLs more affordable, and efforts to promote community cohesion and greater links between people to lessen sanitation-related risks. These solutions include both technical and social elements.

Urban sanitation policy based on technical solutions alone will not result in access to modern sanitation for all. In addition to technical and infrastructural issues, unequal social relations – including gender inequality, intersecting with other inequalities including religion and caste – create discrimination and inequality leading to different experiences of sanitation. Some literature on gender and sanitation recognises identity-based discrimination against women of particular religion or caste, unaffordable cost, and bans on particular women using facilities due to personal whim of the attendant (Actionaid 2013; Osumanu and Kosoe 2013).

PTs, while seen as the best option to manage slum sanitation (Scouten and Mathenge 2010), present gendered hazards for women and children, unless they are well-planned. Toilet blocks are often unlit, making them attractive for illegal activities (e.g. drug use), and for human predators who wait, knowing women or children will come and use them. While women and their families want sanitation facilities, they are therefore wary of using shared or public sanitation facilities that may put them at risk. Maintenance of PTs is commonly a problem due to resources and to lack of buy-in from stakeholders including users.

As a result, PTs often go unused because no one takes responsibility for them (Bapat and Agarwal 2003). If they are insecure or dangerous, filthy, without water, broken, too costly, or

closed at night, women will take the risk of going to urinate and defecate in the open air, in locations referred to by WASH professionals and urban government officials as OD sites. OD sites are found in the open spaces between groups of slum dwellings, on the borders of railway lines or roads, down gullies or on rocky outcrops where construction is impossible, or on the edge of a settlement beyond the current edge of the slum. To allow any form of privacy they need by definition to be isolated, hidden, and unlit, making them unsafe for women and children.

Sanitation programming still tends to happen without full awareness of the role of gender and other aspects of identity in constraining people from accessing sanitation. The effects on women and girls of lack of sanitation are well known; these include health problems and psychosocial stress (Sahoo *et al.* 2015). Pregnancy, menstruation, and menopause and ageing create additional challenges during women's life cycles. Gender inequality creates additional issues. For women, and in particular women in overcrowded, impoverished urban areas, lack of sanitation facilities creates physical insecurity and vulnerability to VAW, including harassment, rape, and assault.

Recent scholarship has emphasised the cross-cutting nature of poverty, caste, religion, and other aspects of identity, which intersect with gender to shape women's experiences of inadequate sanitation (Carrard *et al.* 2013). Women and children face unavoidable risks when they relieve themselves, creating a range of problems and causing acute psychosocial stresses. Because of the state of many PTs in slums, women may see OD as a more appropriate choice. As Deepa Joshi *et al.* (2011, 102) write, 'What is experienced as lack of appropriate sanitation is defined significantly by where one lives'. Distant, open ground may seem more appropriate than spaces closer to home (Truelove 2011), but also a better option than a filthy, insecure PT.

In the next section, we give brief details of our research: locations, participants, and methods.

Our research

Mapping the research locations

An estimated 40 per cent of the population of Pune live in the city's *vastis* (Government of India 2011, 5), or slums, and in Jaipur, the figure is 16 per cent (PRIA 2014, 11). The study was done in three whole slums (Kathputli, Kalakar, and Lal Khan), and Swamion ki Basti (a slum pocket – that is, a small section of a big slum) in Jaipur, Rajasthan; and 11 slum pockets in Pune, Maharashtra (Ambedkar Nagar, Khadda Vasti, Birasdar Nagar, Gosavi Vasti, Laxmi Nagar, Lokamanya Nagar, Ganesh Nagar, Samartha Nagar, Rajiv Ghandi Nagar, Gulab Nagar, and Jaibhim Nagar). The locations for our research were selected with the help of NGOs working in the respective cities.

Due to lack of space we cannot describe the geography of each of these slums in full in this article, but we will focus briefly on a few examples, to enable readers to build up a picture of some of the key issues faced by participants. Some slums are in the heart of the city. Others are far out, in peripheral locations. Slums can be 'declared' or 'undeclared'.[2] Many do not have roads, but stone and concrete slab walkways. Open drains

are common. The housing pattern varies, with houses made of plastered or unplastered brick and concrete floors and tin roofs, to rooms of tin covered with tarps or jute sacks. Some slums are electrified. Individual household latrines are almost unknown; some households built IHLs for women and girls, but these were rare.

Kathputli is the oldest slum in the city of Jaipur, at the city centre, with heavy traffic and a varied housing pattern from houses made of poorly mortared brick with tarpaulins or jute sacks instead of roofs to houses of plastered brick and concrete floors, with tin roofs. The land the slum occupies is publicly owned, although this is disputed. It is home to 5,000 people but has PTs in only one neighbourhood, with ten seats for men and ten for women. People here have household taps and public taps for water. Also in Jaipur, the slum of Kalakar is home to around 2,000 people. The area is north of the city centre and some houses have permanent construction, although many have dirt floors. The houses are very small and much activity goes on in the lanes between them. The sewerage system is a network of open drains. The PTs in the settlement are not in use because their construction was never completed.

In Pune, Ambedkar Nagar is a big city centre slum, home to around 10,217 people. It is a declared slum with private land ownership. Some people have private taps, and there are PTs with a caretaker, which the residents can use for a fee. There is an estimated one PT to every 500 people. In contrast, the small slum pocket of Khadda Vasti in Pune is home to 25 families – of around 111 people – who did not leave five years ago when the slum was evacuated. They now live in makeshift shelters on the footpath. There is no water or sanitation, and people practise OD in a space near the railway station. In another undeclared slum in Pune, Samartha, the land is privately owned and located on a hill. It is home to around 1,513 people. It has private drinking water connections, but only one PT located downhill, which is far away and in a filthy condition. There is an estimated one PT to every 1,000 people. Some families have constructed individual household toilets but others have to practise OD in a space on the hill. Finally, in the slum pocket of Ganesh Nagar, home to an estimated 427 people on another hillock in Pune, a tanker brings water every day for which women have to pay Rs 10–20 'incentive' to the tanker driver. There is no sanitation, and dwellers use an OD space located adjacent to the slum area.

In urban India, government provision of sanitation has taken various forms over the years. In some cases local governing bodies have given public land to NGOs for the building of pay-for-use facilities. In other cases, PTs have been built but they have far too few seats, no access to water, and their construction quickly crumbles. While some of these toilet blocks have caretakers, this was unusual in the slums we studied.

Research methods and participants

In our research, we used focus group discussions (FGDs) to give us basic familiarity with each settlement, its amenities, and women's experiences of sanitation-related violence. Women participants for FGDs were gathered by the NGOs working in those areas; some were engaged in NGO activities (like self-help groups) while others were not. They tended to be married women in their middle age, although newly married and elderly

women also participated. These FGDs drew women from a variety of caste/ethnic/religious and socioeconomic groups. We also interviewed women selected from FGDs who were willing to talk in greater depth about their experiences and emotions.[3,4]

We aimed to interview across socioeconomic and geographic conditions in each study site.

All the locations we studied had a mixed caste and class composition. A total of 112 women participated in our research: 58 in Jaipur and 54 in Pune. Eighty-nine of the 112 (79 per cent) were aged between 18 and 45. Sixty-seven of the 112 women were totally uneducated. Women in Pune were roughly three times more likely to have had some formal education than women in Jaipur (12 compared to 34). The majority of women who had ever received education in Pune had been in school for between eight and ten years, while the picture was more varied over the whole spectrum in Jaipur.

Women were classified as either married (79 of 112), widowed (18), deserted (one) or unmarried (11). While all women do unpaid domestic work within the home, 39 of the 112 stated that this was their only work (expressed in our research as 'homemakers'). The rest worked outside their homes for money, providing informal urban labour. Twenty were domestic workers in the homes of better-off families, 16 did home-based work to produce small-scale goods or services, and 11 – all located in Pune – were wastepickers. Other occupations mentioned by relatively few women were construction work, working for an NGO, entrepreneur, dancer, government, *Anganwadi* worker (providing primary health care for pregnant women and young children), student, and beggar.

Caste/ethnic/religious identities are very important in these communities. As we will show, membership of different caste/ethnic/religious communities is a key factor in explaining women's experience – and perceptions of – sanitation-related VAW. The majority of women – 46 in Jaipur and 38 in Pune – were Scheduled Caste, a category including many communities identifying as Dalits, Chamars, Mahars, Nats, Rajnats, and others. Together they are a traditionally poor and stigmatised caste group. A small minority in both contexts were Muslim (seven women in Jaipur and three in Pune). The remaining participants (five in Jaipur and 13 in Pune) fell into the categories of Other Backward Caste, General, Scheduled Tribes, Denotified Tribes, and Nomadic Tribes.

Everyday violence and psychosocial stress: sharing our findings

Four significant themes regarding gendered violence and psychosocial stress emerged from our analysis: first, the theme of slum geographies and types of sanitation space, focusing on those who had no access to IHLs and had to use either PTs, or resort to OD; second, forms of harassment and assault and the experiences of women from different caste/ethnic/religious communities; third, mothers' fears for their daughters; and finally, coping mechanisms. In this section, we offer an analysis of our key findings according to these four themes. For each of these themes, we found that cross-cutting differences in identity – including gender, caste, religion, age, and others – affect women's experiences within the slum environment. The physical environment of the slum including its location, physical features including the natural environment, and infrastructure are all critical, as are social relationships.

Slum geographies and conditions of sanitation spaces

Availability of sanitation spaces was largely determined by the physical and social geography of the slums, and the investment in infrastructure that had been made by government, NGOs, and slum-dwellers themselves. Most of the slums on the outskirts had OD spaces, and those that were centrally located had PTs. Few households could afford IHLs. In some slums, defecation had to happen along the highway in full view of passersby, and/or on open ground without cover.

PTs

In Jaipur, all four slums had PTs, although only one – in Swamion ki Basti – was in useable condition. It had a caretaker, water, and was relatively clean. It cost INR 1 (US$0.02) to use. Another PT in Kathputli was built for the lowest caste group in the slum by a foreign donor, not far from a public tap. Women living nearby declared that the women's PTs were too filthy to be used:

> I had intended to use the PT, but two days after it is cleaned, it is too dirty to be used. (Interview, Jaipur, 3 January 2014)

In another location, Ambedkar Nagar, in Pune, there were five toilet blocks that were in poor condition. Only one of the five toilet blocks here was seen by participants in our research as in a useable condition, due to an on-site caretaker.

Wastepickers in Ambedkar Nagar had a better opinion of PTs over other users. Most said they were well-maintained, although not all thought positively about the facilities. Another woman, who is a domestic worker, from the same slum felt differently:

> The PTs are very dirty. Women eat tobacco and spit in the corners. They use the toilets to dump their sanitary napkins. Seeing all this, I once vomited when I used the toilet. Since then I prefer to avoid going in there if I can. I usually use the toilet in the houses that I work in as a domestic worker or a place of worship where such a facility exists. Otherwise, I prefer the open spaces near my *vasti*. (Interview, Pune, 18 November 2013)

The filth of the PTs in this slum was due to no running water for flushing, and no proper disposal for sanitary pads. Water had to be carried from home or obtained from a single outdoor tap near the toilet. The toilet use was timed, from 6 am in the morning until 11 am at night. Despite the poor state of the toilets, users were charged a fee of R1 per use. Affordability was a concern for women using PTs, and particularly so in situations like this one where payment was per use, rather than per month.

Many women in Pune slums chose to use OD sites because they judged the available PTs to be unsafe and filthy. Most were poorly lit, and the floors were wet and slippery, making them unsafe, especially for elderly, disabled, or pregnant women. The design of PTs, however well-intentioned, sometimes contributes to gender-related risks. For example, one PT had partial walls so daylight could enter and electricity be saved; however, women felt threatened by the possibility of men peeping over the walls and light at night was insufficient for women to feel safe.

Where PTs had women's toilets on the top floor (men's on the ground), women's vulnerability increased because of stairs and landings that were occupied by men drinking or playing cards. At least three slums had liquor stores situated near PTs that had broken, unlockable, or absent doors. One woman particularly mentioned the traumatic experience of looking at sexually graphic graffiti in the Pune slum of Laxmi Nagar, mentioned earlier. Because of the graffiti, she avoided defecating until absolutely necessary.

The opening times of PTs matters very much to women's safety, too. Even if women have access to a PT they feel they can use, they will have to go out in the open if they need to relieve themselves between 11 pm and 5 am. If a PT is only open during the day, the need to work will affect women's ability to use it. In Pune, working women left home by 8 am, and wastepickers even earlier. For these women, this means waiting to defecate later in the day, skipping morning household chores, or going for OD if they are too far from a PT.

OD sites

In Pune, OD sites contributed to creating risk and vulnerability for women because they were at a distant location from women's homes, and had characteristics contributing further to risk: located in scrubland and forests with undergrowth, at the side of railway lines and canals, and on hillsides and erosion gullies. OD sites were usually poorly lit or not at all. Several women narrated instances when steep, slippery sites led to broken legs, and railway tracks led to death. Lokmanya Nagar was located on one of the busiest roads in the city, had no PT, and hardly any open space for defecation.

OD sites often harbour snakes, pigs, insects, and other animals. A Scheduled Caste woman in Ganeshnagar-P narrated the menace of mosquitoes: 'They bite you all over' (interview, Pune, 15 October 2013). Another Scheduled Caste (Dalit) woman, who has now been able to afford an IPL, recalled:

> When I was a girl, my older sister and I went out for OD in the dark. I heard nothing until a dog bit me full in the face. I screamed and went into shock. My sister had to carry me home. For months I could not go out to the OD ground. (Interview, Jaipur, 9 January 2014)

Achieving privacy is impossible. In Kathputli, the OD place was across a dirt lane, busy with foot traffic that ran between the slum habitations and the OD ground. Avoiding anyone in order to get there was impossible at virtually any time of day. Being seen defecating was unavoidable as well – no plant growth existed to hide behind. Similarly, in the slum of Ganesh Nagar, OD simply had to be done along the highway in full view of passersby. Being watched or seen was a constant source of stress. A Scheduled Caste (Dalit) woman from Ganesh Nagar said:

> The defecation site is very close to the road, and therefore there is always a possibility that someone might be passing by. We have to keep looking in every direction for the passersby. Whenever we see someone approaching, we have to stand up, and then sit again when they are gone. (Interview, Pune, 10 October 2013)

When men came near the OD sites, women and girls said they either stood up, or tried to hide their faces, for example with scarves. Another Scheduled Caste (Dalit) woman said:

> We are always eagerly waiting for the evening … If a male acquaintance sees you, it is so embarrassing when you meet him the next time. You can't keep your head down; you have to keep watch, so this is unavoidable. (Interview, Pune, 10 October 2013)

Yet the lack of privacy in OD also means that any attack is likely to be witnessed. One 40-year-old Muslim woman said, 'If I shout, someone will come running' (interview, Jaipur, 28 January 2014).

Violence, harassment, and caste dynamics

Sanitation-related VAW and sexual harassment was a constant threat to all women and girls, regardless of their caste/religion/ethnic identity, and regardless of whether they were using OD sites or PTs. This reality resulted in women consciously making decisions to minimise risk. However, for those who lack appropriate sanitation, what might be considered a 'normal' level of risk avoidance is simply not possible.

In our research, we heard of VAW and harassment that took both verbal and physical forms, and as one Jaipuri young woman told us, 'Looking is also harassment' (interview, Jaipur, 2 February 2014). In both Jaipur and Pune, women reported instances of harassment faced either by themselves or by other women known to them. Forms of harassment reported included men watching women during OD, perched in treetops, water tanks, and inside canals. They took pictures. A young Scheduled Caste (Nat) woman expressed her feelings this way,

> Teasing and watching are too normal to get worried about. It just happens. That's all. (Interview, Jaipur, 10 February 2014)

For her, harassment had become normal; since it was a usual occurrence, she had rationalised it by persuading herself that women should not fret over it.

Men do more than look; two women from Jaipur told us inappropriate comments were daily occurrences. In the Jaipur slum of Lal Khan, the OD main entrance was a hangout for young men. Young women and girls told us that they never answered back or noticed the loiterers in any way, but it was stressful just to pass by them. One young woman said that she used a short cut to the OD place in order to avoid them. Men also played cards along one perimeter of the OD place. A woman living on the periphery said that she kept an eye out for anything suspicious.

Women with children were also harassed. A wastepicker in Pune said,

> People who live on the footpath, don't like this [children defecating there], and they won't allow us to do it, if they see us. Also, people who clean the roads won't allow it. But there is no other place for children to defecate. (Interview, Pune, 19 February 2014)

Women reported that girl and boy children faced many of the same risks and harassment as adults.

While harassment was common, reports of sexual assault (including male masturbation) were few. In Ganesh Nagar, women specifically mentioned men staring and masturbating in front of them while they defecated. The worst incidents of VAW mentioned in

our research were a rape in Jaipur, and an attempted rape in Pune. The woman who had undergone the attempted rape narrated the incident to us in detail. She observed:

> This place is very unsafe. It doesn't mean that nothing will happen in the future, just because it hasn't happened yet. Women always face a threat of being raped. (Interview, Pune, 10 October 2013)

We believe sexual assault was under-reported, due to the stigma attached to it. Sometimes we were being given accounts which indicated women were not willing to openly discuss instances of sexual assault. An example is that two women in Jaipur simply said a man 'stood' in front of them. The trauma of assault was compounded by community silence on the topic and women's lack of freedom to speak about it to each other, let alone to policymakers, planners, or researchers like us. For example, with bitterness, a 20-year-old Scheduled Caste woman related the story of how – when she was 15 and newly moved to the settlement as a bride – a man came and 'stood' in front of her. She shouted at him, and he ran. She continued, 'I did not tell my husband; I did not want to start a fight'. She concluded in anger:

> Even now, no one tells each other anything! How are we [women] to know what is going on [what to be afraid of]? (Interview, Jaipur, 5 February 2014)

Our interviews reflected this lack of information. We began asking women in Jaipur if they were certain of any sexual assaults occurring. Their response was to reply: 'No, but we know it happens in different places' (interview, Jaipur, 7 February 2014).

Intersectional perspectives: difference among women

A very important and striking finding of the research was the extent to which belonging to a majority community in the slum reduced women's risk of male harassment and violence.

In Jaipur's slums, women of dominant castes claimed that they felt no fear, faced no trouble, and had little experience with harassment. This enabled these women to put distance between themselves and other women's experiences and fears in the settlement.

An upper-caste woman, who was in a minority in the slums, told us how insecure she felt living among 'Dalits', and how she feared for her daughter's safety because of them. Women from that community presented the opposing perspective: they said they did not see a threat from 'other' men, since they saw 'their' men protecting them against sanitation-related violence. In Kalakar in Jaipur, women not belonging to the dominant Kalbelia[5] sub-caste were taunted by groups of Kalbelia boys, who played at the entrance of the OD place. However, Kalbelia women were apparently exempted from harassment: none of them reported experiencing it. In Ambedkar Nagar, in Pune, women said the local political representative had 'fixed' the 'outsiders', i.e. men not local to the area, thereby controlling VAW in the slum. 'Women' is a category that masks multiple differences, so we need not be surprised that caste and community relations presented a division.

Age and stage in the life cycle also created difference in gendered experiences of risk. Women reported that children of both sexes faced some of the same threats as adult women. Age and gender intersect to create particular risks for pre-pubescent and pubescent girls and whether they went for OD or used a PT, many women expressed particular fear for their daughters, rather than themselves. Women were especially concerned about their daughters' safety if they were physically or mentally challenged. Some women reported only letting daughters go for OD at night.

Women also expressed fear of their daughters having an illicit relationship when out visiting the OD site. In a traditional community where high value is placed on chastity before marriage, this is a very real fear. Women in all three Jaipur study sites mentioned that girls and boys met clandestinely at the OD place. A woman in Kathputli-J, who was one of the few upper-caste women we interviewed, told us,

> We had two young daughters, and I did not want them to go in the open any more. So I said to my husband that we will have to build our own toilet, even if we have to cut short on some other things. So when we built this house, we compromised on some other things. We did not build a kitchen counter immediately. But we built the toilet. (Interview, Jaipur, 29 January 2014)

For this woman, her family's minority, upper-caste position in the community made her daughter's safety her priority, and she accompanied her everywhere. She herself had not recovered from an incident when she was followed on her way to defecate.

Regardless of caste status, women said they did not allow their pre-teen and teenage daughters go for OD without them. As a mother lamented, 'once you lose your reputation, it is gone forever' (interview, Jaipur, 28 January 2014). A Scheduled Caste (Bhat) girl in Kalakar-J told us that if her mother cannot leave her current task then she has to wait before going out. A 20-year-old Scheduled Caste (Dalit) girl in Kathputli-J explained how different life was in the slums from life in the suburbs:

> When I am at my brother's house [in the suburbs], I am not afraid to walk on the street or go anywhere. (Interview, Jaipur, 9 February 2014)

In contrast, in the settlement, she was afraid of harassment, and never left the house except with her parents. Whether the fears were their own or their parents' projections, the result was a lack of freedom for teen girls in our study settlements.

The impact of unmet sanitation needs on physical, mental, and emotional health

The impact of having to restrain and control urges to defecate or urinate because of lack of safe, clean, and accessible sanitation facilities has a severe toll on health, in addition to numerous infections contracted from using filthy facilities.

A detailed inquiry into illness was not in the scope of our study, but women complained of skin infections, diarrhoea, urinary and reproductive tract infections, nausea, vomiting, and other illnesses. Mental and emotional health is affected as well as the more obvious and immediate threats to physical health. Sanitation affects all areas of women's and

girls' lives, compromising their ability to work, but also their wider social well-being and relationships. For a woman in Pune, the stress of OD affected her sexual relationship with her husband as she was constipated most of the time. She reported that he suspected her of having an affair, due to her lack of interest in sex.

When we talked to women we tried to ensure we were discussing not only their current experience but also asking about their experiences over time. While the hazards associated with ODs and use of poor PTs were many, some were not constant, affecting some women due to health issues – for example, a need to rush out due to diarrhoea, or the urge to urinate more during pregnancy. Other hazards increased for all women and girls at particular times, for example during particular times of day when boys were gathered around OD sites, and taunting women who went there; or seasonal, as when monsoon rains made OD grounds so disgusting that women reported trying to defecate only every other day.

Our research brought out the multitude of psychosocial stresses that women face due to unsafe, inadequate, or absence of sanitation facilities. Women's stress and struggles around violence-free sanitation varied across a spectrum: from preoccupation with safety to the normalisation of harassment. Women mentioned feeling stress, trauma, shame, anxiety and guilt, embarrassment, and violation.

Experiences of psychosocial stress varied from woman to woman, depending on gender, caste, degree of poverty, age, and marital status. These aspects of personal identity shape women's experience but this is also shaped by the geography of the slums, with their specific characteristics of location, topography, and infrastructure, and the kinds of sanitation facility available to women. The issues also varied according to health and seasonality.

Women's coping mechanisms and strategies to effect change

Following Jo Rowlands (1997, 13), we wish to focus on the relational dimensions of women's power, as these hold the key to our original question: 'If gendered violence is symptomatic of power inequalities in society, then how do those inequalities manifest themselves in women's psychosocial stress and translate into women's decisions about where to relieve themselves?' Women are immersed in multiple relationships that determine the degree of harassment, fear of attack, and comfort when it comes to OD and PTs.

Our research showed the extent of stresses around sanitation but also highlighted women's resourcefulness and pragmatism, strategising to reduce their fear and discomfort. Coping with threats formed a part of women's everyday emotional lives. Remarks like 'What can we do?' and 'We have no choice' give insight into the degree of normalisation of women's fears surrounding OD and PTs. They also may be understood as women's feelings of helplessness around the issue of inadequate sanitation and its associated risks.

We found that women and girls feel they have to take responsibility for, or keep silent about, incidences of harassment. Social pressure means women and girls are under strain to preserve their reputations based on their behaviour outside their homes, and we found

women blamed men from other communities for the risk, insecurity, violence, and harassment they feared and experienced.

A crucial point is that women themselves are more likely to analyse their experiences in terms of inter-communal harassment or violent acts committed by 'outsiders' than finding common ground with other women. We found women in our research showed little hesitation pointing out caste/sub-caste groups that engaged in harassment, but sexual assault was always attributed to an outsider. This may be because women were reluctant to name someone in their small communities; but it also suggests that men outside community sanctions seized opportunities to assault when they presented themselves. Notably, in both Pune and Jaipur, women's triumphant responses to attackers were against outsiders. Women related how their husbands discouraged their involvement in conflicts and women expressed suppressing an urge to confide in their husbands about experiences of violence.

Individual and household-level strategies

Women's greatest exercise of power lies at the most intimate scale: that of bodily control. In response to these issues, women and girls have developed strategies and coping mechanisms to deal with the challenges of sanitation in the slums. The most common way of coping is developing 'body discipline' (that is, trying to control bodily functions so that urination and defecation were as infrequent and safe as possible). Going out accompanied by other women, or husbands, also ensures women are safer than they are on their own by reducing vulnerability to accidental injury, and from violence and harassment. The ultimate goal women mentioned to solve the problem was being able to leave the group of people dependent on public sanitation or OD, by constructing and owning an individual toilet.

Women everywhere were knowledgeable about the safest times to go out for defecation. In order to avoid needing to go at other times, bodily discipline was much discussed. This was achieved by eating less at night, avoiding too much food and drink, avoiding spicy food, and using anti-diarrhoeal tablets to stop bowel function when necessary. Echoing the sentiments of others, a woman from Samarth Nagar in Pune told us:

> In case of upset stomach I either take a medicine, or eat something cold – like curd or ice-cream – to avoid going during the night. (Interview, Pune, 9 October 2013)

This woman said that she followed these preventive measures whenever there was no one to accompany her to the defecation site. A common individual coping mechanism reported was to go with a group of women either in the daytime or with husbands or other male household members at night. Some women wanted their husbands along; some husbands insisted on accompanying their wives. This reduced the risk of accidents. However, because it also reduced the risk of attack or harassment, this coping mechanism is simultaneously a strategy to challenge and reduce violence now and in the future. Yet as an action that takes place on the level of individuals and their households, it has limited scale and impact.

If we look at the struggle for sanitation as a struggle over sanitation 'resources' (that is, a safe, private, hygienic facility that is constantly available to those who need it), gendered negotiations around the safe use of OD and PT sites were to the disadvantage of women, while men were relatively privileged. Women's double burden of homemaker/caregiver and paid employee was illustrated in the lives of the women we spoke to. Many women faced greater or specific stress due to their specific needs to get out of the house for work, or took advantage of jobs with toilets even at reduced wages.

Without the protection of a husband, widows faced more physical insecurity, but married women recounted that their husbands set limits on their movement, time spent going for OD, and time of day of going out. Household gender relations were not necessarily antagonistic, however. Existing dangers meant a woman could successfully ask her husband to accompany her to the PT or OD ground.

Some husbands also responded to their wives' requests for IHLs for themselves or daughters.

Women's preferred solution to the stress of inadequate sanitation was to build IHLs. For most of the slum-dwellers in Pune and Jaipur, access to an IHL was financially out of reach. Existing IHLs were in either wealthy households or in the homes of those with disabilities or illness. In Jaipur, most often it centred on a pre-teen daughter and the need to build it before she got much older. Young women and girls were most at risk of VAW and harassment and the risk of attack created the need for women to accompany daughters to toilets or OD. This was a stressor not only because of their fear for their daughters, but also because of the time that it took from paid work and household chores.

Despite the risks faced by women and girls, male household members did not always immediately see the benefit of a household latrine. In Lal Khan, Jaipur, where women did piecework or worked outside their homes, two households reported building toilets, so that they could gain time for paid work. Two newly married young women who had grown up with IHLs fought with their husbands and in-laws to argue the need to build an IHL, and toilets were built in both cases.

Yet low rates of income, job insecurity, and land tenure insecurity played significant roles in decisions not to build. Women in Pune spoke frankly: 'We do feel like building our own toilets but the space too is not our own' and 'It's a vicious cycle since we don't have assured land titles, we cannot build toilets. Moreover constructing toilets is very expensive'.

Lack of space to build and the lack of drainage were other major hurdles reported.

Private or public building of IHLs across slums is not likely given financial and spatial constraints, unless city governments commit to investing in sewerage systems. That leaves PTs as the cost-effective option, but PTs are already 'magnets' for those who wish to harass or attack women and girls.

Individuals can fight for their own interests: 'I always fight back', said a Scheduled Caste (Rajnat) woman in Jaipur said (interview, 9 February 2014). Women may also intervene on behalf of each other, on an individual basis; another Scheduled Caste (Dalit) woman in Jaipur said she chased away a boy harassing a girl, but she did so without telling her husband who would have scolded her for interfering.

Finding solutions at scale in the slums: possibilities and constraints

Accounts of women's empowerment emphasise the role of collective action in increasing the 'power-to' of the individual so that it becomes part of the larger 'power-with' of the group (Rowlands 1997).

Where caste, sub-caste, or slum solidarity was strong, our research found that women did gather courage to counter harassment in a tough way: 'We are able to shout and beat men up if we are in bigger groups', said a woman from Ambedkar Nagar (interview, Pune, 29 November 2013). A group of women in Kathputli-J and wastepickers in Ambedkar Nagar did exactly that, and brought the man to the police station. Women also 'carry stones and masala [spice] along so that if some such incident were to take place we can take care of ourselves', said a woman from Ganesh Nagar (interview, Pune, 14 October 2013). This was echoed by other women from Birasdar and Ambedkar Nagar.

Inter-caste solidarity between women was also present. A story of inter-caste assistance came from an 18-year-old Scheduled Caste (Bhat) girl who told us boys from the Jogi community had helped her:

> My friend and I went for OD. As we were squatting there, some [Scheduled Caste] Jogi boys shouted to us that a man was watching us and we should run away. Then those Jogi boys beat the outsider up. I told my parents, and I told my sister about the nightmares I had afterwards. (Interview, Jaipur, 4 January 2014)

Most of the stories women told us were about the dangers of girls speaking to boys outside their sub-caste, but her story was of aid between sub-caste groups.

The idea of collective action to demand sanitation was mentioned in the research: wastepicking women demanded PTs in the 1990s after violence against women going for OD galvanised them. Yet PT technology on its own has not solved the issue of sanitation in the slums. PT sustainability is a key concern given the scale and levels of need, and the inequalities in social relationships that perpetuate risk and lack of access. Gendered sanitation-related violence is as much about inequalities as technical solutions. Some women will continue to use PTs regardless, but many others return to OD with all its associated fears and threats.

Collective action to advocate for more and improved PTs and to create communities which work together to maintain them is a challenge. Women in the slums differ not only in age from each other, but in caste, relative poverty, and other aspects, creating inequality between them. Tensions between groups play out in gendered ways, including – as we saw in our findings – VAW and harassment.

The possibilities for women joining forces across caste groups in Jaipur seemed to us to be small; communities in the city appeared to be viciously caste-divided, as evidenced by a riot in one of the slums during our interview period. Little community support in Jaipur was evident against sanitation-related violence or for the provision of sanitation, although occasionally women from multiple castes worked together in egregious cases of harassment.

In comparison, the situation in Pune was different: a mixed-caste group had demanded PTs from the city, and got them in 2000, although clearly this provision did not meet needs,

as our research shows.[6] Wastepickers in Pune seemed to draw strength and motivation from being part of a union. The respondent who told us this said at the time the union was founded and collective action began, there were no toilets in the *vasti*, and women often faced violence. Men used to hide in the bushes and grab women when they went for defecation, so a group of women came together to demand a PT. As a result, a few PTs were constructed by the Municipal Corporation (interview, Ambedkar Nagar, 19 November 2013).

However, given the many ways that slum populations were distinct (that is, according to degrees of poverty) and chose to distinguish themselves (e.g. via notions of belonging and 'othering' playing out as caste pride/prejudice), solidarity over sanitation issues seems to us to – at least currently – be unlikely.

Conclusion

We believe that research like ours, that focuses on the common ground and differences in women's stories about sanitation add nuance to mainstream policy debates and can assist in the development of policies that will lead to sustainable sanitation. Women's own stories demonstrate how complex inequalities of gender, caste, and other aspects of difference create a need for appropriate sanitation that keeps children, adults, and households safe from sanitation-related ill health and stresses.

Notes

1. In Pune, NGOs involved were: SAMYAK, Kagad Kach Patra Kashtakari Panchayat, Khelghar, Bahujan Hitay, Pune Project – Jeevak; in Jaipur: Participatory Research in Asia (PRIA – Jaipur).
2. 'Declared slums' are those recognised by the government and therefore eligible for some basic services such as water and sanitation, as opposed to 'undeclared slums', which are considered to be illegal by the government and therefore not deserving of any basic services.
3. FGDs and interviews were not recorded; instead, notes were taken and then typed. Typed notes were coded by recurring themes and analysed by the authors. The research was approved by the Texas A&M Institutional Review Board and the Institutional Review Board of Chest Research Foundation, Pune.
4. The Swacch Bharat Abhyian – Urban (Clean India Mission – Urban) guidelines suggest that one seat in a PT is enough to serve the needs of 35 people. For women, the norm is 25 to a seat and for men it is 35 to a seat (Government of India, Swacch Bharat Mission – Urban Guidelines).
5. The Kalbelia caste traditionally earns its living through dancing, which is in particular demand for tourist performances in Jaipur.
6. For further information on the wastepickers union in Pune, see www.kkpkp-pune.org/ and www.swachcoop.com/.

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