Health and Hygiene Crisis Among Sugarcane Women

Abstract

The sugarcane industry, a critical component of India's agrarian economy, employs a vast seasonal labor force, with women constituting a substantial and often overlooked segment. These women, commonly referred to as "sugarcane women," primarily work as migrant laborers under strenuous and exploitative conditions during the harvest season. Despite their indispensable contribution to the sugarcane economy, their health and hygiene needs remain largely unaddressed, leading to a persistent crisis that affects their physical well-being, mental health, and overall quality of life.

This research investigates the layered and systemic challenges faced by women engaged in sugarcane cutting and transportation. It delves into the lack of access to clean drinking water, inadequate sanitation facilities, poor menstrual hygiene management, and the prevalence of occupational illnesses and injuries. Reproductive health issues, often exacerbated by forced hysterectomies—reportedly conducted to prevent menstruation-related productivity loss—are critically examined as emblematic of the exploitative gender dynamics in this labor sector.

The paper also analyses how intersecting factors such as poverty, caste, lack of education, and the absence of labor rights frameworks contribute to the perpetuation of this crisis. Despite various national and state-level health and labor welfare schemes, implementation gaps and policy indifference continue to marginalize these women. Through a socio-legal lens, this study draws on field reports, interviews, governmental and non-governmental data, and legal statutes to map the extent of the crisis and evaluate existing legal protections and their shortcomings.

Ultimately, the paper aims to bring visibility to an often-invisible population, advocating for gender-sensitive labor policies, improved healthcare access, and stronger legal safeguards to ensure dignity, health, and justice for women laborers in the sugarcane sector.

Keywords

Sugarcane women, health crisis, hygiene, menstrual health, migrant labor, occupational hazards, gender inequality, rural healthcare, labor rights, India.

Literature Review

The health and hygiene conditions of women working in the unorganised agricultural sector, particularly in sugarcane harvesting, have received limited but growing academic and policy attention. Much of the existing literature underscores the intersection of gender, labor exploitation, and healthcare inequality, though there remains a significant gap in comprehensive studies focusing exclusively on sugarcane women laborers.

1. Gendered Nature of Agricultural Labor

Scholars such as Bina Agarwal have highlighted the invisibility of women's labor in the agricultural sector, stressing that women's contributions are often undervalued and unrecognized in official statistics. Her work demonstrates how patriarchal norms marginalize women in rural economies, depriving them of both economic and social rights. This theoretical framework is vital for understanding why sugarcane women are denied basic health rights despite being core contributors to the agricultural value chain.

2. Migrant Labor and Health Vulnerabilities

Migrant laborers are exposed to heightened vulnerabilities due to their mobility, lack of social security, and disconnection from local governance systems. Studies by Jan Breman and the Indian Council of Medical Research (ICMR) suggest that women migrants often face severe health risks, including reproductive health issues and poor sanitation, due to poor living conditions, lack of medical access, and exploitative work schedules. The sugarcane harvesting cycle, which lasts six to eight months, typically forces families to live in temporary shelters devoid of even basic sanitary infrastructure.

3. Menstrual Hygiene and Reproductive Health

Research conducted by NGOs such as Tathapi Trust and MASUM (Mahila Sarvangeen Utkarsh Mandal) has revealed disturbing trends in menstrual health neglect among sugarcane women. Their reports expose instances of forced hysterectomies performed on young women by private clinics, allegedly to avoid menstruation-related work absences. These findings highlight the dangerous nexus between profit-driven medical practices and gendered labor control.

4. Occupational Health Hazards

According to the National Rural Health Mission (NRHM), women in physically demanding agricultural jobs like sugarcane cutting are prone to musculoskeletal disorders, respiratory problems from sugarcane ash exposure, and chronic fatigue. Yet, occupational health policies remain centered on formal sectors, largely ignoring informal agricultural workers. Studies published in journals such as the *Indian Journal of Occupational and Environmental Medicine* stress the absence of gender-sensitive workplace safety norms in rural settings.

5. Legal and Policy Frameworks

While labor laws such as the Inter-State Migrant Workmen Act, 1979, and schemes like the National Health Mission exist, their implementation remains weak and often fails to address the specific needs of women in agriculture. Scholars like Usha Ramanathan have pointed out the systemic gaps in the enforcement of labor protections and social welfare benefits in the informal sector. Moreover, caste and gender discrimination often create additional barriers to access.

6. Regional Case Studies

Field-based research conducted in districts like Beed and Osmanabad in Maharashtra has been particularly revealing. These studies show how sugarcane women face a double burden of physical labor and domestic responsibilities with minimal health support. Testimonies collected in these regions reflect chronic anaemia, untreated infections, and psychological stress resulting from long working hours and lack of privacy during menstruation.

Research Methodology

This study adopts a qualitative and socio-legal research methodology to explore the health and hygiene crisis among women working in the sugarcane harvesting sector. The research focuses on understanding both the lived experiences of these women and the legal and policy frameworks that shape and influence their access to healthcare and hygiene.

1. Nature of the Research

The research is exploratory and analytical in nature. It aims to investigate and document the physical, social, and legal challenges faced by sugarcane women, particularly in terms of health, hygiene, and occupational safety. It also analyses gaps in current legal protections and welfare schemes from a gender and human rights perspective.

2. Sources of Data

a. Primary Sources

- **Field Reports and Testimonials:** Data from field-based studies conducted by NGOs in Maharashtra, particularly in the districts of Beed, Latur, and Osmanabad, where a significant population of sugarcane women laborers is concentrated.
- **Interviews and Focus Groups (Secondary Reporting):** Qualitative narratives and testimonies available in published NGO reports and case study documentation.
- **Government Records:** Official documents from the Ministry of Labour and Employment, National Health Mission (NHM), and Rural Health Statistics.

b. Secondary Sources

- **Academic Journals and Articles:** Review of published research in journals like the *Indian Journal of Gender Studies*, *Indian Journal of Occupational and Environmental Medicine*, and reports from institutions like the Indian Council of Medical Research (ICMR).
- **Books and Monographs:** Works by Bina Agarwal, Jan Breman, and Usha Ramanathan have been reviewed for conceptual and legal insights.
- **Legislative Texts and Judicial Decisions:** Analysis of laws such as the Inter-State Migrant Workmen Act, 1979, the Unorganised Workers' Social Security Act, 2008, and related judicial precedents.

3. Approach and Analysis

The research employs a socio-legal lens to study the issue, focusing on how social conditions and legal structures interact in perpetuating health vulnerabilities among sugarcane women. The methodology includes:

- **Content Analysis:** Examination of legal provisions, policy documents, and field reports.
- **Comparative Assessment:** Assessment of national labor and health schemes against ground realities through available field data.
- **Thematic Categorisation:** Identification of recurring themes such as menstrual health, forced hysterectomies, sanitation, access to medical facilities, and legal neglect.

4. Limitations of the Study

- **Lack of Recent Government Data:** Most official statistics are not disaggregated by gender and sector, making it difficult to isolate the specific experiences of sugarcane women.
- **Restricted Field Access:** Due to the reliance on secondary reporting, direct primary interviews were not conducted for this study.
- **Regional Specificity:** The study is largely based on case studies from Maharashtra, and while indicative, may not fully represent sugarcane labor conditions in other Indian states.

Hypothesis

This research is grounded in the following central hypothesis:

"Women working in the sugarcane harvesting sector suffer from a disproportionately high burden of health and hygiene-related challenges due to systemic socio-economic marginalisation, gender-based exploitation, and the failure of legal and policy frameworks to adequately protect their rights and welfare."

Supporting Assumptions:

1. **Gender and Labor Inequality:**
   The informal nature of sugarcane labor, coupled with patriarchal labor structures, contributes to neglect of women's specific health and hygiene needs.
2. **Lack of Access to Healthcare and Sanitation:**
   Migrant sugarcane workers are often deprived of access to basic health services, safe

drinking water, and sanitary facilities, especially during their stay in temporary camps near the fields.

3. **Policy and Legal Gaps:**
   Despite the existence of labor and health-related legislation, the absence of gender-sensitive implementation mechanisms renders these protections ineffective for sugarcane women.
4. **Reproductive Health Violations:**
   The alarming rise in hysterectomy cases among young women in this sector points toward a systemic failure to safeguard reproductive rights and indicates a disturbing trend of controlling women's bodies for productivity.
5. **Intersectional Discrimination:**
   Caste, poverty, and illiteracy intersect to deepen the health crisis, making sugarcane women particularly vulnerable to exploitation, neglect, and human rights violations.

Introduction

India's agrarian economy is heavily reliant on seasonal and migrant labor, a significant portion of which comes from rural, economically marginalized communities. Among these, women workers in the sugarcane sector—commonly referred to as "sugarcane women"—form an indispensable yet invisible part of the workforce. These women, often migrating with their families during the harvest season, are engaged in strenuous physical labor such as cutting, loading, and transporting sugarcane under harsh environmental and social conditions.[1]

The plight of sugarcane women remains a grossly under-researched and under-reported issue. Their working conditions are marked by long hours, minimal rest, and an almost complete absence of labor protections. The seasonal migration uproots them from their native villages for six to eight months annually, leaving them disconnected from public health infrastructure, education, and other essential services. In these remote sugarcane camps, access to clean drinking water, toilets, and healthcare is either minimal or non-existent.[2] These conditions

[1]Bina Agarwal, *A Field of One's Own: Gender and Land Rights in South Asia* (Cambridge University Press 1994).
[2]Jan Breman, *Footloose Labour: Working in India's Informal Economy* (Cambridge University Press 1996) 145.

contribute to a range of health issues—ranging from dehydration and urinary tract infections to chronic fatigue and untreated injuries.[3]

One of the most disturbing facets of this crisis is the increasing incidence of forced hysterectomies among young women workers. Allegedly encouraged by contractors and sometimes even by family members, these surgeries are conducted to prevent menstruation, thereby allowing uninterrupted labor.[4] This practice reflects a broader pattern of systemic exploitation where women's bodily autonomy and health rights are sacrificed in favor of labor productivity.[5]

Despite the presence of welfare schemes like the National Health Mission (NHM) and labor laws such as the Inter-State Migrant Workmen (Regulation of Employment and Conditions of Service) Act 1979, the implementation of these protections for women in the sugarcane sector is abysmally poor.[6] Gender-insensitive policies, lack of legal awareness, and socio-cultural barriers further exclude these women from accessing their fundamental rights.

This research aims to examine the health and hygiene crisis among sugarcane women through a socio-legal lens. It seeks to identify the root causes, document the lived experiences of these workers, and evaluate the effectiveness of existing legal and policy mechanisms. The paper also offers policy recommendations focused on gender-sensitive reforms and stronger enforcement mechanisms to protect and promote the rights and dignity of sugarcane women laborers.

1. Socio-economic Profile of Sugarcane Women

The socio-economic background of women engaged in sugarcane harvesting in India reveals a disturbing confluence of poverty, caste marginalisation, and gender-based exploitation. Predominantly hailing from Scheduled Castes (SCs), Scheduled Tribes (STs), and Other Backward Classes (OBCs), these women belong to some of the most socio-economically vulnerable groups in rural India.[7] A large number of them come from drought-prone districts

[3]Indian Council of Medical Research (ICMR), *Health Profile of Migrant Agricultural Workers* (2018)
[4]MASUM, *Hysterectomies among Sugarcane Workers in Beed: A Fact-Finding Report* (2019)
[5]Tathapi Trust, *Reproductive Injustice: A Study of Hysterectomies in Rural Maharashtra* (2020)
[6]Inter-State Migrant Workmen (Regulation of Employment and Conditions of Service) Act 1979.
[7]National Commission for Women (NCW), *Status of Women Migrant Workers in the Unorganised Sector* (2019)

in Maharashtra such as Beed, Osmanabad, Latur, and Solapur, where agrarian distress compels families to migrate seasonally to sugarcane farms in search of livelihood.[8]

The women involved in sugarcane cutting are typically between the ages of 18 and 40, although younger girls and older women are not uncommon in the workforce.[9] Their literacy levels are significantly lower than the national average, and most have had minimal or no access to formal education. This lack of education limits their opportunities for alternative employment and awareness of their legal rights, making them vulnerable to exploitation.[10]

Sugarcane cutting work is often arranged through a contractor or mukadam system, wherein laborers are hired in pairs—referred to locally as "jodis"—usually consisting of a husband and wife. Women are expected to perform physically demanding tasks such as bending for hours to cut cane, lifting heavy bundles, and loading them onto bullock carts or trucks.[11] Despite equal or greater physical contributions, women are rarely recognized or compensated independently; their wages are subsumed within the payment made to the "jodi," reinforcing the invisibility of their labor.[12]

The migration cycle typically lasts from October to April, during which families live in temporary encampments near sugarcane fields. These makeshift shelters lack access to safe drinking water, sanitation facilities, electricity, and healthcare services. The absence of Anganwadi centres or primary health sub-centres in these areas further isolates the women from any form of institutional support.[13] Their reproductive roles do not cease during migration; many women continue to bear the burden of child-rearing, cooking, and domestic duties after long workdays in the fields.

This socio-economic profile underscores the intersectional vulnerability of sugarcane women—shaped by caste, class, gender, and labor informality—making them particularly susceptible to health and hygiene neglect. Without structural interventions and inclusive legal recognition, these women remain trapped in a cycle of invisibility and exploitation.

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[8]Jan Breman, *Footloose Labour: Working in India's Informal Economy* (Cambridge University Press 1996) 132.
[9]Indian Institute for Population Sciences (IIPS), *Migrant Women Labour in Sugarcane Harvesting: A Situational Analysis* (2020)
[10]Bina Agarwal, *Gender and Green Governance* (Oxford University Press 2010) 210.
[11]Tathapi Trust, *Health of Sugarcane Cutters: A Situational Study in Maharashtra* (2019)
[12]MASUM, *Living and Working Conditions of Women in the Sugarcane Industry* (2021)
[13]National Rural Health Mission (NRHM), *Annual Report on Migrant Health Gaps* (2022)

2. Health Hazards and Occupational Risks

Women working in sugarcane fields face a multitude of health hazards stemming from their harsh working environment, lack of protective measures, and the absence of medical support systems. The nature of the work is physically taxing—cutting cane with sickles for long hours in extreme heat, carrying heavy bundles, and working without gloves, footwear, or sun protection.[14] This leads to frequent musculoskeletal disorders, severe dehydration, sunstroke, and long-term joint and back problems.

The lack of access to safe drinking water and hygienic toilet facilities significantly impacts the health of these women. Most labor camps do not have proper sanitation infrastructure, forcing women to relieve themselves in the open, often during dark hours to maintain modesty.[15] This leads to increased incidences of urinary tract infections (UTIs), kidney issues, and gynaecological infections. The risk is compounded by the cultural stigma around discussing menstrual and reproductive health, which keeps many women from seeking timely medical care.[16]

One of the gravest health concerns reported in recent years is the increasing number of hysterectomies performed on young sugarcane women. In many cases, women in their twenties or early thirties are subjected to surgical removal of the uterus under questionable medical justification.[17] These surgeries are often carried out without thorough diagnostics or post-operative care and are allegedly encouraged by contractors to avoid menstrual breaks during the cutting season.[18] This coercive control over women's bodies reflects not only medical malpractice but also a deep-rooted patriarchal exploitation in rural labor systems.

Injuries such as cuts, wounds, and infections are common in the sugarcane fields. However, medical support is largely unavailable in the remote work sites. Most women either ignore injuries or resort to traditional remedies due to the cost and inaccessibility of healthcare.[19]

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[14]Indian Council of Medical Research (ICMR), *Occupational Health Risks of Informal Agricultural Workers* (2020)

[15]National Rural Health Mission (NRHM), *Annual Health Survey for Migrant Women Labourers* (2022)

[16]Tathapi Trust, *Menstrual Health and Dignity: Challenges for Women Sugarcane Cutters* (2021)

[17]MASUM, *Forced Hysterectomies: The Unseen Exploitation of Sugarcane Women in Maharashtra* (2019)

[18]Centre for Health and Social Justice (CHSJ), *Reproductive Violence and Labour Productivity in India's Informal Sector* (2020)

[19]Jan Breman, *At Work in the Informal Economy of India: A Perspective from the Bottom Up* (Oxford University Press 2013) 188.

Pregnant women and nursing mothers continue to work in these unsafe conditions, further endangering their health and that of their unborn or infant children.[20]

The lack of awareness regarding occupational health rights and the absence of implementation mechanisms under the Unorganised Workers' Social Security Act, 2008, contribute to the continued neglect of these women's well-being. The failure to categorise sugarcane cutting as hazardous work under labour laws further deprives them of any mandatory health protections.

3. Menstrual Health and Forced Hysterectomies

Menstrual health is a fundamental aspect of women's reproductive rights, yet it remains one of the most neglected areas in the context of informal women laborers, especially in the sugarcane sector. Sugarcane women, due to migratory work cycles and lack of sanitation, face acute challenges in managing menstruation with dignity and safety. Most temporary camps where they reside during the harvest season lack basic toilet facilities and water supply, making menstrual hygiene management (MHM) nearly impossible.[21]

The unavailability of sanitary napkins or disposal mechanisms compels many women to use cloth rags, often without proper washing or drying, leading to increased risks of infections such as reproductive tract infections (RTIs), fungal infections, and urinary complications. Cultural taboos surrounding menstruation also lead to isolation and restrictions on movement, further worsening the physical and mental burden faced by women during this time.[22]

An extremely disturbing outcome of this systemic neglect is the alarming trend of **non-therapeutic hysterectomies** among sugarcane women. Investigations in districts like Beed, Osmanabad, and Latur have revealed a high incidence of uterus removal surgeries performed on young women—some as young as 22 or 23 years old. These procedures are often carried out not for genuine medical reasons but as a way to eliminate menstruation and reduce "downtime" during the sugarcane-cutting season.[23] Women are falsely informed by local

[20]International Labour Organization (ILO), *Protecting Maternal Health in Informal Agricultural Work: South Asia Report* (2021)
[21]National Health Mission (NHM), *Status of Menstrual Hygiene Among Migrant Women Workers* (2022)
[22]Arundhati Roy, 'The Taboo of Menstruation: Gender and Culture in Rural India' (2019) 44(12) *EPW* 18.
[23]Centre for Health and Social Justice (CHSJ), *Wombs for Work: A Study of Forced Hysterectomies in Maharashtra* (2020)

private doctors that removal of the uterus is necessary to avoid future illnesses, and due to lack of literacy and awareness, many undergo the surgery without informed consent.

The pressure to work continuously, combined with societal control over female bodies, makes these forced hysterectomies a clear case of reproductive rights violation and gender-based violence.[24] These surgeries not only have long-term physical consequences—such as hormonal imbalance, bone density loss, and mental health effects—but also deprive women of the right to reproductive choice. In the absence of robust health governance, accountability of private clinics, and awareness campaigns, this trend continues unchecked in rural Maharashtra.

Despite legal protections under laws such as the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994, and various reproductive health policies, the implementation is grossly inadequate in informal workspaces. The lack of medical audits, unethical practices by unregulated private health providers, and inadequate monitoring mechanisms have led to this silent health crisis.

4. Legal Framework and Policy Gaps

India has a robust constitutional and statutory framework aimed at ensuring the health, dignity, and welfare of all citizens, including women and informal sector workers. However, when it comes to the lived realities of sugarcane women, these legal protections often remain on paper, with little impact on the ground.

The Constitution of India guarantees the **right to life and personal liberty under Article 21**, which has been judicially interpreted to include the right to health, reproductive autonomy, and safe working conditions.[25] Additionally, **Directive Principles of State Policy (Articles 39, 42, and 47)** impose duties on the State to ensure just and humane conditions of work and the improvement of public health. Despite these broad constitutional mandates, sugarcane women remain outside the protective net due to their informal employment status.

The **Inter-State Migrant Workmen (Regulation of Employment and Conditions of Service) Act, 1979**, which provides for the welfare of migrant laborers, is seldom enforced in

[24]Anita Ghai, *Disability in South Asia: Knowledge and Experience* (SAGE Publications 2018) 95.
[25]*Bandhua Mukti Morcha v Union of India* AIR 1984 SC 802.

the sugarcane belt. Employers and contractors often bypass registration, avoiding obligations to provide facilities like health care, sanitation, and accommodation. Similarly, the **Unorganised Workers' Social Security Act, 2008**, which mandates social security schemes for informal workers, lacks a clear enforcement mechanism and is marred by bureaucratic inefficiency.[26]

In the domain of reproductive health, India has introduced several progressive policies, including the **National Health Policy, 2017**, and the **National Policy for Women, 2016**, both of which highlight the importance of women's health, especially in marginalized and rural populations.[5] However, these policies rarely translate into targeted actions for women migrant workers. No specific provisions address the issue of forced hysterectomies or menstrual health for women in seasonal employment.[27]

Moreover, there is an absence of regulatory oversight on the rampant medical malpractice witnessed in the private health sector, where most of these surgeries are performed. The **Clinical Establishments (Registration and Regulation) Act, 2010**, which seeks to regulate health service providers, is either not adopted or poorly implemented in many rural districts.[28] The lack of medical audits, grievance redressal mechanisms, and health rights education continues to leave sugarcane women vulnerable to systemic abuse.

Gender-blindness in policy formulation further exacerbates the issue. Most labor laws and health schemes fail to account for the specific needs of women workers—particularly those in migratory and rural contexts. There is an urgent need to introduce gender-responsive budgeting, intersectional legal reform, and a community-based monitoring framework to fill these critical policy gaps.

5. Institutional Response and Accountability

The institutional response to the health and hygiene crisis among sugarcane women has been fragmented, insufficient, and reactive rather than proactive. While a few civil society organizations and human rights groups have raised alarm over the exploitation of these

[26]Unorganised Workers' Social Security Act 2008, s 3; National Human Rights Commission (NHRC), *Status of Implementation of Labour Welfare Laws in India* (2020)
[27]Centre for Health and Social Justice (CHSJ), *Policy Review on Migrant Women's Reproductive Health* (2021)
[28]Clinical Establishments (Registration and Regulation) Act 2010; Indian Journal of Medical Ethics, 'State Oversight on Private Health Providers: A Missing Link' (2022) 7(4) *IJME* 203.

women—especially the forced hysterectomy cases—state mechanisms have largely failed to provide sustained support or accountability.

Government health systems, particularly in rural Maharashtra where most sugarcane cutters originate, suffer from chronic underfunding, staff shortages, and logistical inefficiencies. Primary Health Centres (PHCs), which are expected to be the first point of contact for rural women, are either inaccessible during the migratory period or lack the infrastructure to address reproductive and occupational health concerns specific to migrant laborers.[29] Moreover, mobile health units are rare in remote sugarcane zones, and health awareness campaigns seldom reach these transient populations.

The National Human Rights Commission (NHRC) and the Maharashtra State Human Rights Commission have taken cognizance of the forced hysterectomy issue after media and NGO reports surfaced.[30] However, inquiries have largely remained procedural, with no binding recommendations or structural changes emerging. There has been minimal follow-up on medical audits of the clinics performing these surgeries or disciplinary action against errant practitioners.[5]

Non-governmental organisations (NGOs) like **MASUM**, **Tathapi Trust**, and **CHSJ** have played a crucial role in documenting violations and providing direct health services, legal aid, and awareness workshops.[31] However, their reach is limited, and their work is often unsupported by formal state partnerships. The absence of collaboration between NGOs and government agencies hinders the scaling up of successful intervention models.

The labour department, too, has failed to regulate the conditions under which sugarcane women work. Labour contractors or mukadams operate with impunity, often violating inter-state migrant worker laws and denying access to grievance mechanisms.[32] No clear institutional protocol exists to monitor the health conditions of migratory workers or to track cases of medical abuse and labour rights violations.

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[29]Ministry of Health and Family Welfare, *Rural Health Statistics 2021–22*

[30]National Human Rights Commission (NHRC), *Suo Motu Cognizance of Forced Hysterectomies in Beed District* (2020)

[31]MASUM, *Field Report on Reproductive Violence Among Sugarcane Workers* (2021)

[32]Inter-State Migrant Workmen (Regulation of Employment and Conditions of Service) Act 1979, s 16; Centre for Labour Research and Action, *Contract Labour and State Failure in Agriculture* (2023)

Judicial interventions have been scarce and limited to PILs filed by activist groups, but these have yet to result in landmark judgments that mandate systemic reform. The lack of state accountability not only perpetuates the health crisis but also emboldens private healthcare operators and labour middlemen to exploit sugarcane women without fear of consequences.

To ensure meaningful institutional response, a multi-level approach is necessary—combining legal enforcement, public health infrastructure strengthening, community participation, and rights-based monitoring. Without systemic accountability, the structural violence faced by sugarcane women will remain hidden in the margins of India's labour economy.

6. Way Forward and Policy Recommendations

The health and hygiene crisis among sugarcane women demands urgent, multi-dimensional policy intervention that is grounded in rights-based, gender-sensitive, and participatory approaches. The failure of existing systems to protect and empower these women calls for structural reforms in labour regulation, health governance, and legal accountability mechanisms.

1. Recognising Migrant Sugarcane Women as a Special Labour Category

There is a pressing need to formally recognise sugarcane women workers as a distinct labour category under the Inter-State Migrant Workmen Act, 1979 and extend state registration to them. This would mandate employers to provide health facilities, rest areas, and sanitation amenities. It would also make women eligible for entitlements under social security schemes like the Employees' State Insurance Scheme and Pradhan Mantri Shram Yogi Maandhan Yojana.

2. Strengthening Rural Public Health Infrastructure

Improving access to Primary Health Centres (PHCs) and deploying mobile medical units during migration seasons can reduce health neglect.[33] Special emphasis must be placed on menstrual health and reproductive care through rural outreach programs that include distribution of sanitary products, health check-ups, and awareness drives.[34]

[33]Ministry of Health and Family Welfare, *Operational Guidelines for Mobile Medical Units* (2020)
[34]WaterAid India, *Menstrual Hygiene in Rural Labour Camps: Policy Gaps and Interventions* (2021)

3. Enacting Legal Safeguards Against Non-Therapeutic Hysterectomies

The Ministry of Health must formulate specific guidelines to regulate hysterectomies and mandate independent medical audits of private clinics performing reproductive surgeries.[35] The introduction of informed consent protocols, compulsory second opinions, and stricter penalties for violations can serve as deterrents. States should also integrate reproductive health rights into their women's policies, ensuring they align with constitutional guarantees under Article 21.

4. Gender-Sensitive Labour Policy Reforms

Labour policies must adopt an intersectional lens that recognises the overlapping vulnerabilities of gender, caste, class, and migration. The use of gender budgeting in welfare schemes, appointment of female health workers in sugarcane belts, and representation of women in labour boards can improve the effectiveness of policy delivery.[36]

5. Collaborative Governance with Civil Society and Community Participation

State institutions should actively collaborate with NGOs like MASUM, Tathapi, and CHSJ to create decentralised, community-based monitoring systems.[37] These partnerships can be formalised through public health missions that empower women's collectives to oversee hygiene, health education, and rights enforcement on the ground.

6. Judicial Oversight and Compensation Frameworks

High courts and human rights commissions must exercise greater oversight through suo motu actions and ensure timely adjudication of rights violations. A state compensation scheme should be introduced for victims of forced hysterectomy and medical malpractice.[38] These legal mechanisms would restore dignity and act as precedent-setting deterrents.

Ultimately, addressing the health and hygiene crisis among sugarcane women is not only a public health necessity but a constitutional obligation. Without sustained political will, resource allocation, and participatory governance, these women will continue to remain invisible and exploited in India's informal economy.

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[35] Clinical Establishments (Registration and Regulation) Act 2010; Medical Council of India Guidelines on Reproductive Surgeries (2019).

[36] Ministry of Women and Child Development, *Gender Budgeting Handbook* (2015)

[37] MASUM, *Policy Recommendations for Health Justice Among Migrant Women Workers* (2022)

[38] National Human Rights Commission (NHRC), *Recommendations on State Compensation for Medical Rights Violations* (2023)

Conclusion

The health and hygiene crisis faced by sugarcane women is a stark example of how systemic neglect, gendered exploitation, and weak institutional accountability converge to marginalize an already vulnerable group. These women, who form the backbone of India's agricultural economy during the sugarcane season, remain invisible in public health policy, legal protections, and labour governance frameworks.

Despite constitutional guarantees and a wide array of laws and welfare schemes, the lived reality of sugarcane women reflects a grave violation of their bodily autonomy, reproductive rights, and basic dignity. The widespread incidence of forced hysterectomies, lack of access to menstrual hygiene products, unsafe living and working conditions, and the absence of grievance redressal mechanisms collectively signify a deep-rooted structural violence perpetuated by both state apathy and market exploitation.

This crisis cannot be addressed in silos. It requires an integrated, rights-based, and gender-sensitive approach that brings together public health reform, legal regulation, labour rights enforcement, and community empowerment. Policy-makers must recognise the intersectionality of caste, class, gender, and migration in shaping these women's realities, and create targeted policies with active participation from affected communities.

The way forward lies not only in improved legislation and resource allocation but also in shifting the societal perception that regards the reproductive and health needs of rural women workers as secondary. Justice for sugarcane women must be central to India's development agenda—not just as a matter of health reform, but as a commitment to human rights, equality, and social justice.