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Shodhini: A Alternative Women-Centred Health Care Approach

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Introduction

The women's health movement in India today is fast gaining momentum, although there continues to be a vast gap between ground realities and women's aspirations. Women's groups are extremely active and are working towards the betterment of health care services nationwide. Most importantly, they have brought the so-called modern health care system into question. It is against this backdrop that the Shodhini experience is set.

Dissatisfied with modern health care services, eager to under- stand the care of our own bodies and to discover the efficiency of traditional herbal remedies, we came together, women's health activists from different parts of India, to form the Shodhini network.

This book is the story of the Shodhini experience.

In The Beginning

Shodhini's genesis lies in a national consultation of women's groups working in the field of health. In October 1987, in SRED Tamil Nadu, 50 women's health activists from both rural and urban areas all over India congregated to discuss the state of women's health. Also present at this consultation was Rina Nissim of the Geneva Women's Health Collective. The discussions revealed that the interests of urban and rural women were substantially different. Urban women were keen to learn about the use of traditional remedies and plants in women's health from rural women. Rural women, on the other hand, wanted to learn about the use of traditional remedies and plants in women's health from rural

women. Rural women, on the other hand, wanted to learn about modern developments in health, they wanted information to which they had no access. Further discussions showed that there existed very little knowledge about systems other than allopathy for treating women's common problems. Women's traditional knowledge for managing their health problems appeared to be dying out. On the other hand, it was felt that, medical care fails to reach the vast majority of Indian women. Inadequately staffed government health facilities, a health care system that looks at women only as 'mothers' to be targeted for family planning and population control policies, indifferent, and sometimes even hostile, personnel manning (literally) the primary health centres, make a mockery of programmes for women's health. In light of this situation, the participants at this meeting mooted that alternatives needed to be created to make quality care available for women. They argued further that, traditionally, women have been health care providers. Patriarchal forces have succeeded in reducing their roles and pushing them into subordinate positions within the hierarchy of the medical system. Women, therefore, need to reclaim their power and assume their rightful place.

The consultation led to the formation of a small group of women under the banner of "Action Research on Alternative Medicine and Women's Health" with Rina Nissim as the convener. The group consisted of women from grassroot organisations like Deccan Development Society (DDS), Action India, Aikya, SARTHI, Eklavya, Sadguru Water Development Foundation, Sabla Sangh and Vikalp; from support organisations like CHETNA; and from women's research and documentation organisations like Jagori and Anveshi. This field-based group was supported by a number of people all over India among whom mention must be made of Indira Balachandran, phytochemist at Arya Vaidyashala, Kottakal, Kerala; Shyama Narang, a gynaecologist based in Bangalore; and Tanushree Gangopadhaya an activist based in Ahmedabad.

Thus Shodhini was born as a collective effort to create an alternative for women's health. It sought to empower women by validating their traditional knowledge and enhancing its status, to increase women's control over their own bodies and their own health by training local women in simple gynaecology, and to increase women's control over technology and resources by growing medicinal plants.

Shodhini's primary focus has been to discover meaningful alternatives in health that would respond to women's health needs in India, especially the needs of socio-economically marginalised women. Ours has been a woman-oriented approach aimed at evolving a simple, natural and cost-effective health care system. This approach to health care, particularly when done in a group setting,

with group discussion, is appropriate for all women including those in less economically privileged classes or countries. In addition, the therapeutic methods used in self-help, which are based on elements which the earth gives us in the form of locally available herbs, are applicable everywhere. Believing in the validity and usefulness of the above approach, Shodhini's efforts in working towards alternatives, moved across four distinct phases:

1. Collection of information on plants and natural elements commonly used for women's health problems

2. Training local women health workers/healers in herbal medicine using self-help and a holistic approach

3. Field testing and validating the use of common herbs in a systematic way at the community level

4. In the process of working on the above three phases, developing a team of concerned women and 'barefoot gynaecologists' who will continue and sustain the work of developing alternatives in women's health care.

The process of gathering relevant information about plants was long-drawn and required nearly 18 months. During this time, we also had discussions and meetings with different groups of women from the organisations mentioned above, to find out more about the common yet neglected health problems of women in their region. Our investigations and field interactions with women revealed that many of them suffer from gynaecological problems, which they feel shy and afraid to talk about and hence these remain hidden and neglected. These findings corresponded to the study of Bang, et al. We found that apart from gynaecological problems, anaemia, night blindness and bodyache are also neglected.

It was precisely these neglected but common problems of women that we wanted to identify and enable the women to deal with. Thus, through a series of meetings, discussions and dialogue with various regional women's groups, we arrived at the following areas for our action research.

- problems of the menstrual cycle

- urinary tract and vaginal infections

- uterine and cervical tumours, benign and malignant

- problems during and after pregnancy: anaemia, nausea, lactation failure, weakness, etc.

- other neglected aspects of women's health-back pain, joint pain, weakness, genital prolapse (vaginal, uterine and rectal), fatigue and depression

The Shodhini Method and Methodology

The Shodhini experiment has been informed by a feminist framework and the related critique of modes of research and inquiry. Specifically, we have seen research in women's health as a process of cooperative inquiry whose goal, as it seeks 'truth', must be empowerment of women. The self-help methodology of exploration, diagnosis and treatment, as well as Shodhini's recourse to plant-based medicines and other non-drug therapies, are the means of achieving this goal.

Self-help groups are support groups whose members come together regularly to deal with a common problem. When it comes to women's health, self-help groups are where women come together to learn about their bodies and to help each other deal with common symptoms and problems. The process also helps to enhance the self-esteem and self-confidence of the women involved. The self-help movement grew out of women's realisation that we have been dispossessed of an immense knowledge, and thus power, by the medical profession in a patriarchal system. Obstetricians and gynaecologists who are vested with the responsibility of looking after women's health, treat women as passive objects. Women are thought to be incapable of understanding their bodies, of taking decisions related to their bodies or their health. Self-help groups reflect values, which are important to women, and try to ensure that information relating to our bodies and our health is accessible to all. Implicit in these groups is the belief that we have the capacity to understand medical information. Experiences of group members are an important source of information about health, illness and treatment.

The self-help approach is different from modern, western medicine in yet another area-profit. The pharmaceutical industry and highly technological diagnostic facilities are known for creating, rather than serving, needs. They are part of the larger capitalist logic of profit maximisation. In contrast to the passive consumerism encouraged by modem medicine and the 'information-for-sale-to-be-jealously-guarded' attitude of modern medical practitioners, self-help seeks to encourage autonomy through information sharing and control over resources.

As the saying goes in Kannada, Hitalla geda madalla (I do not look at the plant that grows in my own back yard). For most of the diseases, from which we suffer, there are cures in the plants available in our own back yard. Even if we have this knowledge we do not use it, but choose expensive tablets and drugs instead. The saying goes, 'Instead of using finger nails to remove the dirt, we make use of a huge stone,' For diseases, which can be cured at home, we give money to the doctor for a cure.

Savitri, Aikya

In the course of Shodhini's work, we formed self-help groups at three levels. There was a core group of about ten women with whom the self-help methodology was first tried out. Different core group members initiated self-help groups with the health workers in their respective field organisations. These health workers in turn formed village-level women's self-help groups. Feedback links were maintained between each level and this contributed to the collection of rich experience, creating waves of liberating energy.

After self-help groups were formed, we found that our health workers became confident about their own bodies. M our health workers understand the rhythm method and can recognise their ovulation day. Now they are even talking about condoms. It is certainly because of the contribution of our health workers that women have become confident enough to ask their husbands to use condoms. Even men have begun asking health workers about condoms.

Uma, DDS

Self-help methodology is a means of discovering aspects of ourselves that have been hidden in fear, shame and embarrassment. It is a means of coming to terms with our wholeness, a means of reclaiming our power.

We discuss further, in Chapter 2, the details of training for self- help. In Chapter 3, we discuss the use of plants as part of self-help.

Shodhini and the Allopathic Approach

How then does Shodhini's approach differ from a typical allopathic gynaecologist?

The major difference, perhaps, is that we in Shodhini believe, first and foremost, that women's experiences of health and illness need to be expressed and made visible. In what terms does each individual woman describe her own experience of her body and her health? What is her definition of a healthy woman? We feel that any health care provider first has to understand where the woman, the 'client' or 'patient' if you will, is coming from - what effect her set of experiences and her relationships have on her body and her mind. Only after appreciating and understanding the subjective experiences of her 'patient' can a health care provider begin to use her own specialised knowledge and skill. In fact, the health care provider, from Shodhini's perspective, should have the ability and sensitivity to relate her own knowledge to her client's life experiences, to arrive at a diagnosis. Gynaecologists may ask, "How is our history-taking different from the `subjective experience' that Shodhini is advocating?" Gynaecologists, we feel, base their history-taking on a set of assumptions and facts defined by their knowledge system which only serves to limit their inquiry. There is perhaps, an insufficient grappling with the framework of their 'patient's' knowledge and belief systems.

The second major point of difference between Shodhini's approach and classical gynaecology is Shodhini's commitment to the principle that information is power. We believe that women should be given full information (in terms that they can understand) about their problem or disease and how it affects their bodies and their minds. We believe that demystification and depro-fessionalisation are essential for enhancing people's control over their own situations. Very few gynaecologists (or professionals for that matter) are willing to spend time with their clients and share their own knowledge. Few possess the humility to try and discover what their client already knows, believes or feels about her own problem. Control of knowledge is one of the most critical arenas of feminist struggle.

The gynaecologist's mode of operating is one of treating a patient with a set of interventions (like medicines, CAT scan, surgery, etc.), which will act on her

body. Shodhini's attempt on the other hand, is to help the client create a set of conditions, which can aid healing: healing of the body, the mind and relationships. The client is in control, she is an equal participant, along with the health care provider, in her own healing process. Together they make decisions about what needs to be done. In the other mode the patient is merely a body, a black box, on whom the specialist, the gynaecologist, performs a set of operations to control the outcome.

Shodhini as Feminist Research

An important reason why even female gynaecologists operate in this mechanistic way, and are loathe to trust the subjective experiences of their female clients, is that the knowledge and practice of medicine, as also psychology and psychiatry, tend to be enmeshed with male-defined constructions of women's bodies and minds. Shodhini attempted to create a space where women's experiences, women's voices, and their understanding of their own bodies could be made visible. It attempted to insist upon the experience and the very existence of women as important. Feminists have stressed the need for a 'reflexive sociology in which the sociologist takes her own experiences seriously and incorporates them into her work' (Helen Roberts 1981). Shodhini is an example of reflexive feminist action research. All of us, as women researchers, made visible our own concepts of our bodies, health and disease. No judgement was made about individual experiences, beliefs and practices that women shared. The attempt truly was to validate our experiences.

Shodhini also tried to integrate feminist theory, methodology and practice and to avoid the type of academic discourse that renders research findings inaccessible. We felt that when doing research with relatively powerless groups, research findings should be presented so as to be as clear as possible to those groups. At each step and in every which way, the research findings were being made available to a larger community of women. For instance, the validation of traditional remedies through the first round was fed back into the research process as 'field trials' of the 'A' remedies (see Chapter 3).

Meaning and Identity

Our experience of action research affected us deeply. For all of us it was a reaffirmation of our identities as women, as individuals who can take charge of our lives and connect in meaningful ways with our consciousness as women. We

share below some typical responses about why our co-researchers participated in the Shodhini experiment and what the experience meant for them.

After going to the self-help group (with Rina) there has been a change in my life, in my practice and in my understanding. I have learned about how the body is made and how it functions, I did not know about my own body and how it feels to touch it. I learned how to examine and how to distinguish an infected vagina from a normal one. I learned about hormones and the menstrual cycle. Before, I did not know the importance of doing a physical examination. For three years now I have been doing this. Consequently, along with my increased awareness, adding to my existing knowledge and use of herbs, I have gained enough confidence to conduct meetings with local women and to share this understanding. I began visiting them in their houses to examine them whenever necessary. This built up a demand for the use of herbal remedies for women's health.

I wish to teach others the method of preparing and prescribing medicines so when I die, the art, which I have learned, will not die along with me. Other generations should continue with this.

Halamma, Aikya healer

I became interested in women's health because I myself had weak health and experienced severe heal h problems from childhood. I wanted to gain more control over health. The women's movement was the best place for me to learn about this, rather than medical school, because I had realised t my health problems were often related to what I was experiencing as a girl child and then as a woman. For most of us women it is easier to fall sick than to revolt.

Rina Nissim, Shodhini

I had thought that excessive bleeding, white discharge, abortions, childlessness, etc., are dangerous and incurable diseases. I was also very shy and scared to discuss anything to do with the body; but after this training I learned that diseases are common to all women and that by the use of herbs we can cure such diseases. With this confidence and belief I started telling people about this. I learned that nothing is impossible in the face of persistent effort.

Laxmi, a traditional healer, Aikya

After the loss of my first child, I used to live in constant doubt. Is there something wrong with my reproductive system? Do I have a congenital abnormality? Am I normal? The first self-help session helped me see that there is no abnormality in my organs. This lifted such a load off my chest.

Smita, CHETNA

Halamma, Rina, Laxmi and Smita are part of Shodhini, women from different economic and cultural backgrounds, who came together to create workable and empowering alternatives for our health as women. We discovered our strengths and limitations, reaffirmed our beliefs and laid to rest our doubts both in ourselves as well as in the process of our research.

It needs to be said, however, that our experience, valid though it be, raises a number of questions, questions in search of an appropriate and an adequate theory of knowledge. In the last chapter, we discuss some of these issues and some of the insights we gained.