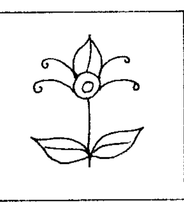
It needs to be said, however, that our experience, valid though it be, raises a number of questions, questions in search of an appropriate and an adequate theory of knowledge. In the last chapter, we discuss some of these issues and some of the insights we gained.



2 Training in the Self-help Approach

AIMS OF SELF-HELP

The Shodhini experiment, as mentioned in Chapter 1, consisted of self-help experiences at three levels: among the core group, at the four voluntary agencies with the health workers, and at the community level with the village women. Feedback links were established between each level and the process grew richer with the two-way flow of experiences. This chapter describes the salient features of the self-help experience at all three levels.

The main aims of the self-help approach were to enable us to:

- look at health in a holistic way, as something conditioned by our physical, psychological, social, political and environmental situation;
- help us internalise the ethos of mutual support and sharing;
- demystify the knowledge of our anatomy and physiology through self-examination;
- learn different ways of remaining healthy.

Our Initial Reactions

When we in the core group started our association with Shodhini, some of us had a theoretical and intellectual understanding of the self-help approach and methodology. Initially it was difficult to move away from the paradigm of providing or seeking symptomatic treatment for physical complaints. It took us a while to learn that the best support we can give a friend has to be defined by *her* needs and world-view and not by our frames of reference. None of us had been part of a women's self-help health group and none

part of the self-help movement in the West. We had to overcome a great deal of resistance over self-examinations. We did not really see how they could lead to empowerment. The resistance took the form of questions like, "Why is it necessary that the training for gynaecology be through self-help and self-examination?" and "Why can't we call in a gynaecologist or a trained nurse and have them teach us?" The intitial stance of each new Shodhini member tended to be, "I don't see the relevance of the self-help approach for my rural situation." Basically each one of us was covering her extreme unease at having to expose herself in public. It was suggested that we conduct the self-examination in private (alone) and then we could discuss our experiences in the group

Ultimately, it was only in the fourth meeting, in July 1990, that we took the leap as a group. This particular self-help session had far reaching personal consequences for many of us as well as for the development of Shodhini as a group. Many of us now feel that the event brought about a significant change in our feelings about our bodies. What we earlier considered as something not-to-be-talked-about (either because we considered it dirty or shameful or because we were taught to be secretly proud of its form and power), in fact became a very natural, beautiful and intrinsic part of our womanhood.

Our experiences as middle class, urban women were somewhat different from tribal and dalit women. For instance they were not as self-conscious and were perhaps more comfortable with their bodies than we were.

With changed perceptions of our bodies, many of us experienced a reduction of our inhibitions and a tremendous freedom of expression in many spheres of our lives and in our relationships. Sharing our experiences at a later workshop, we realised how, for Smita, these self-help sessions had resulted in her assuming a greater personal control within her family situation. For Anu, these sessions had resulted in coming to terms with her inability to conceive, and deciding that there were other options available for her.

Translating Self-help into a Rural Setting

Reflecting on the experience we realised that we had internalised the truth that self-help is a tool for empowerment. Having gone

was not as difficult for the rural women in our group to enter the self-examination experience as it was for urban women. They did need, however, to be provided a clear context before they would participate in these sessions.

There were three field areas where the self-help methodology had first been initiated among the rural women before the Shodhini network went through its own experience of self-examination. In two of these three instances, there were acute problems and work could not proceed. The main reason was that Shodhini members working in that field area had not gone through the process themselves and thus had difficulty in convincing their male colleagues of the relevance of the self-help approach. If the men in charge of the voluntary group could not understand, appreciate or support an activity in the field, it was bound to fail. The following incident illustrates how SARTHI coped with the situation.

Within SARTHI, an explosive situation was created by some of the women health workers (WHWs) who had run out of the first self help session and spread rumours about the "activities" in the little training room. The entire organisation was abuzz with stories of the immorality of the women in the training room. These rumours also spilled over onto a group of visiting rural women who were at SARTHI to be trained as paravets. That night an emergency staff meeting was convened and the self-help training was placed in a proper perspective. The Director of SARTHI quoted a newspaper report about the prevalence of sexually transmitted diseases (STDs) in the Panchmahals district; the coordinator of the women's programme drew attention to the fact that we had lost Champaben because her cervical cancer could not be diagnosed and treated early enough. We appealed to all the staff members that, at this stage, we required their support to make this programme acceptable to the community. This was a challenge, not only for the group of women health workers (WHWs) in the self help session but for the entire organisation. Several staff members sought information on the contents, the expected outcome of the self-help sessions and the future of the women's health programme. Clear and full information was given and the staff were told that whenever they had any doubts or apprehensions relating to self-help training they were to address these to

The Initial Self-help Workshops

Instead of starting with anatomy and physiology, we opted for the methodology adopted by the Brazilian educationist, Paulo Freire. According to him, theory and praxis do not exist apart: each individual's personal and social reality is related in a 'dialogical encounter' with that of the others. In our methodology too, we have very consciously led the women in our groups to analyse aspects of their own existential experience.

> When I was asked in the meeting about my life story, I was scared and I felt very shy. Later, when I went through the self-examination, Rina explained to me that women have different kinds of problems but we do not express them. Through this I gained some confidence. I learned to find out about the diseases that existed in other women. I learned how to ask them and make note of it. I learned to make use of herbal medicines without wasting the plants that grow in the back yard.
>
> *Lakshmi, Aikya health worker*

Starting a Self-help Workshop

A typical self-help group, in its first workshop, began by each member sharing the story of her body and the education received about it. In a quiet place where the women would not be disturbed by their children, each one talked about her personal life in specific relation to her body: "When and how did I learn about menstruation? What was I told about it? What and how did I get information about my body? What and how did I know about bodily pleasure? What are the health problems I experience—and if any have remained uncured, what is/are the reason(s) for them remaining uncured?"

The fund of information that was gathered by this exchange was indeed a revelation. Not only did it help us to identify the most common complaints and ailments of women that are neglected, but with each one's personal experience it motivated us all to get better equipped to confront those problems or complaints. Each person stated what her current symptoms were, if any. The resource person, Rina in this case, would then go on to explain the philosophy of self-help and what we would be doing in these sessions. A self-examination session was also part of the

experience had been for us. Tools used for self-examination—speculum, gloves, mirror, torch—were another feature of the discussions in the first workshop.

The subsequent four or five workshops were woven around the individual symptoms of group members. Step-by-step, we learnt on each other how to interview a 'client' and get a detailed case history, how to record this on the pictorial case sheet which was designed for this purpose, and how to arrive at a diagnosis. We learnt to include the nutritional and mental health aspects in our history-taking and also to provide support in dealing with the chronic and current stress factors.

Field Testing and Documentation

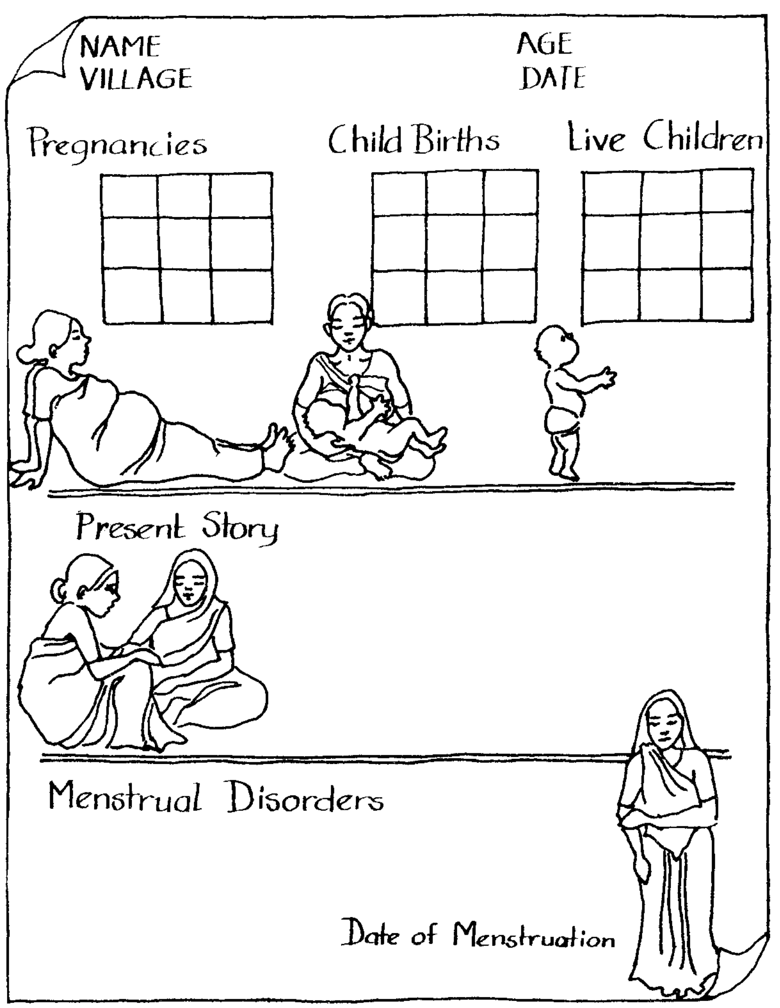
History

A format was developed to help us go systematically into the history of a woman's experiences and stories. The format included:

- number of pregnancies
- number of deliveries
- major health events in the woman's life—serious illnesses

4. first day of last menstruation and usual rhythm of the menstrual cycle (between first day of previous period until first day of next period)
5. details of dietary intake
6. details of any current stressor

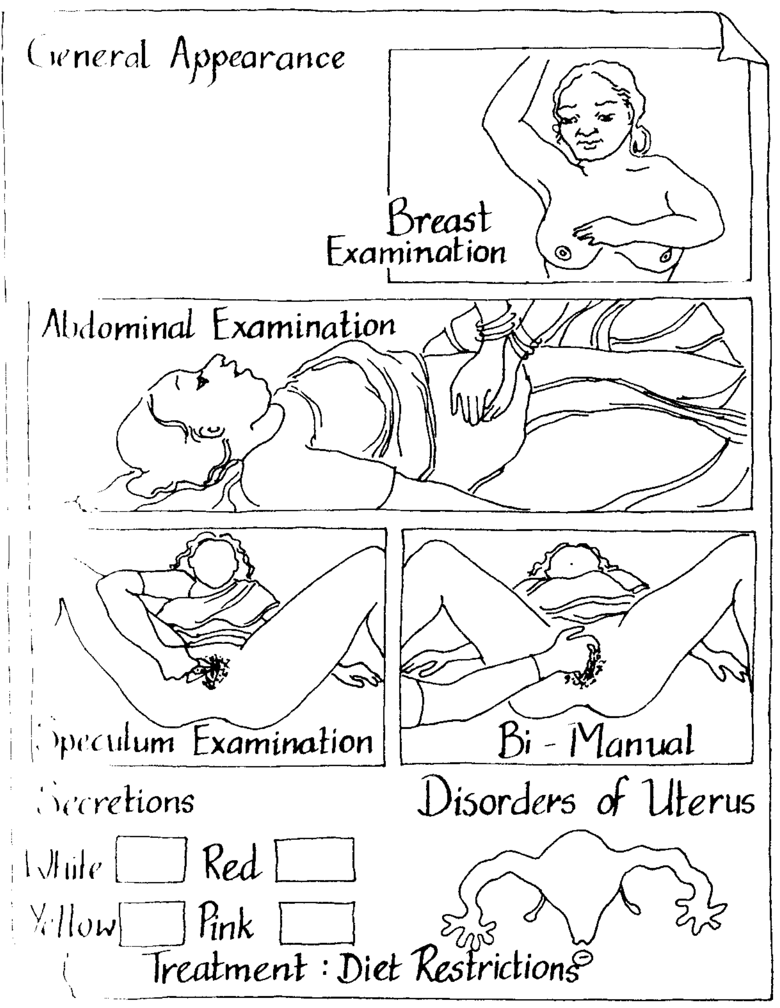
This format helped us develop an understanding of the health of the client. The information was obtained through conversation



rather than a formal, structured interview, with emphasis on developing sensitivity and empathy towards the woman. This informal method of interviews can provide a lot of information problems with sex life, status of dietary intake, any major stresses and chronic ailments.

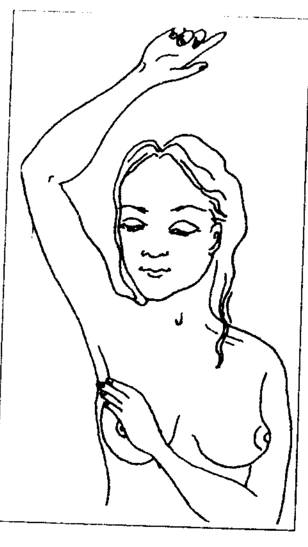
Observation

Observation includes general appearance. Is the woman too thin?



Too pale? Worried or strained? What colour are the inner part of the lower eyelids, the tongue, nails, etc.

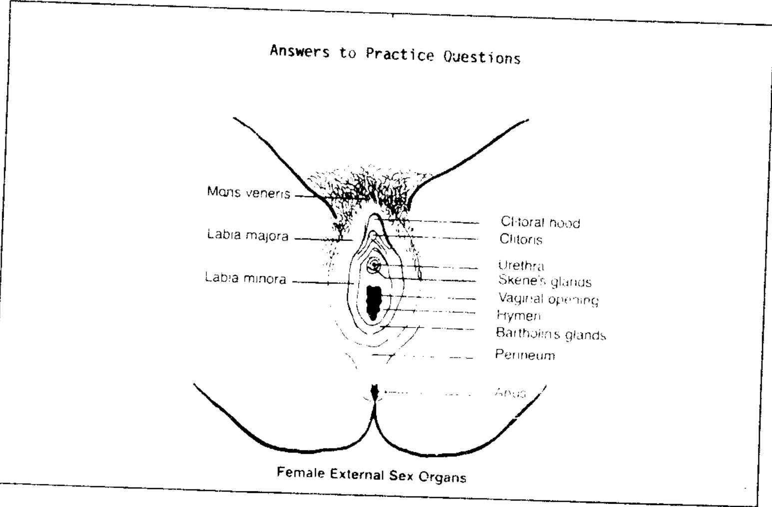
Next we suggest doing an abdominal examination by touching and feeling for any signs of liver or spleen enlargement. This is called palpation. At this stage a breast examination is also done—women can be taught how to do this each month after menstruation.



Pelvic examination

For this examination we use a torch light, a speculum (plastic or metal), a mirror and gloves. Ask the woman to pass urine before examining her. The healer should wash her hands with soap and water. The woman should get into a relaxed position on the floor, with a pillow (if there is one easily available) under her shoulders for support, legs outstretched.

Ask her to look at her vagina and familiarise herself with the structure of her genital parts, like the vulva, clitoris, inner lips, vaginal openings, urethra etc., with the help of a mirror.

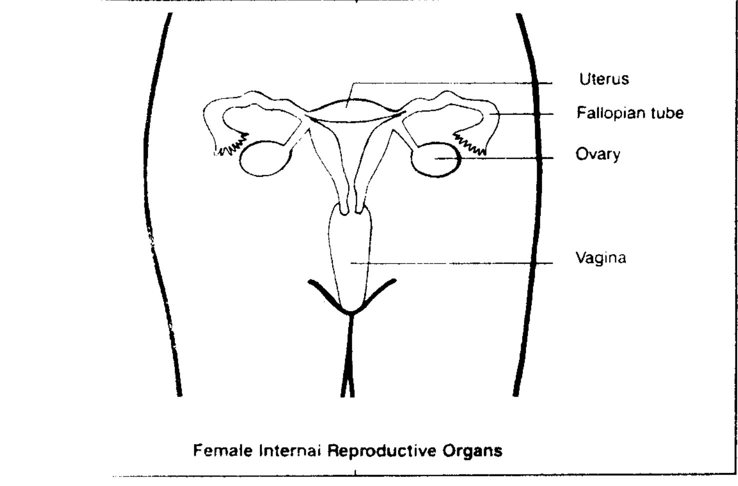


Female External Sex Organs

When examining the vulva, the whole group checks for redness, swelling and any unusual discharge. If the woman is familiarised and confident with the opening and closing of the speculum she can do the examination herself. Encourage her to insert the speculum on her own. If it is difficult, ask her to relax her muscles as much as possible by taking deep breaths. If it is still difficult, readjust the speculum or try a different size.

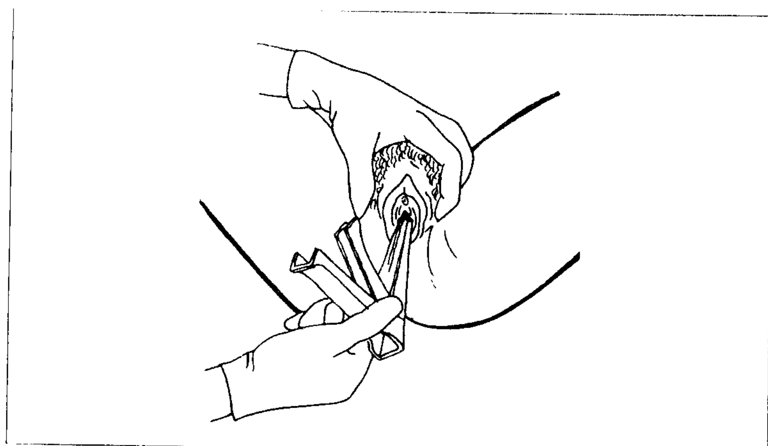
Once she is confident that the speculum is inside, open the speculum. Examine the vaginal walls for lesions, inflammation, or unusual discharges. Check the cervix (now visible), its colour, shape and any unusual discharge. Give her a hand mirror to see the vagina and cervix on her own. If she cannot see, help her to position the torch. This gives an opportunity to learn how and what to look for when examining the cervix in a self-examination.

After removing the speculum, the woman and group may share their observations and feelings.

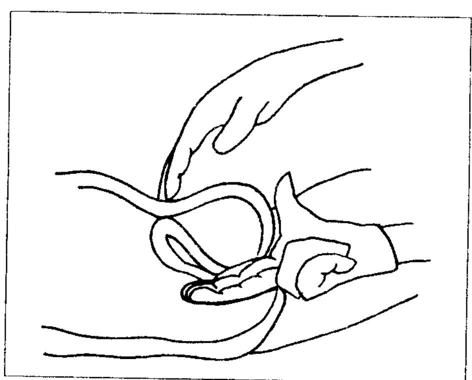


Female Internal Reproductive Organs

If the woman is ready, a bimanual examination can be performed by a person experienced in the technique. Put on a glove (disinfected overnight in antiseptic solution and then sprinkled with perfume-free powder to keep it from sticking together). Insert one finger into the vagina and gently enter the cavity up to the cervix; check for any growth or pain. Then insert two fingers keeping the palm up. If it is painful at first, ask her to contract



her vaginal muscles like she would if she wanted to hold back her urine. Place the two fingers gently under the cervix and with the other hand on the lower abdomen try to join your two hands to evaluate the position, size and shape of the uterus in between. The reading might not be very clear at first but, with experience, it will improve.

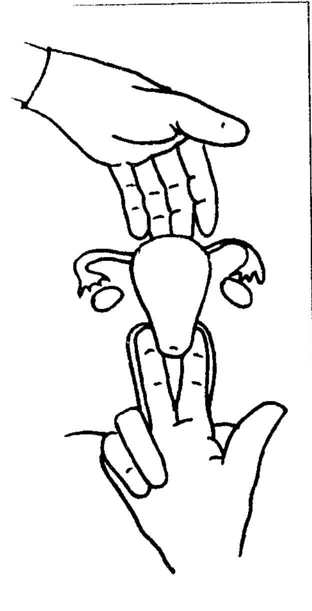


The bimanual examination will be more comfortable if the woman can relax her abdomen and breathe slowly and deeply, exhaling completely.

By examining each other, we learn more about what is normal, what the discharges look like, the colour, size, shape of the cervix and the changes in mucus during different stages of the menstrual cycle.

Urine Examination

Information on urine and urination are among the most indicative signs of the general health of a person. In addition to the vaginal self examination, any symptoms related to the urinary system can give information about vaginal infections. Ask the following



frequency of your urination? in stopping or starting of urination? pain or burning on urination? dribbling?

Collect the urine samples in a clean, transparent glass bottle or tumbler. Take two to three different samples and observe the colour, cloudiness, pus or blood cells. Probe into other signs and symptoms like pain, chills, redness, itching, etc. and also record her diet (for more information refer to Chapter 6 on urinary tract infections).

Diagnosis

What is the significance of all this information?

Example 1: the woman complains of excessive white discharge. Before giving the eventual remedy, you have to diagnose by your own observations whether:

- the secretion is really excessive or is it ovulation time
- there is an infection, inflammation, itching, pain
- the discharge is due to anaemia and malnutrition

The remedies that are prescribed will definitely not be the same in the three cases namely, anemia, infection, hot/cold imbalance. (See Chapter 5 for more details.)

Example 2: the woman complains of excessive bleeding. You first have to make sure you properly understand her story and bleeding pattern. Ask her:

- How long is the cycle normally (normal: 21 to 35 days)?
- Is there any bleeding in between?
- How long is the menstruation itself (normal: 2 to 7 days)?
- How is the flow—light or heavy?
- How often do you have to change? (every 2-3 hours is heavy, every 1/2 hour is haemorrhagic).